Middle Articles

Social Workers and General Practice

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Summary: Weekly case conferences have been found valuable in the management of problem families in a general practice in a new town. These are attended by health visitors, mental welfare and child care officers, welfare officers, and psychiatric social workers, as well as by the family doctors. The conferences are a quick and easy way of exchanging important information and leading to rapid decisions.

The family doctor is being increasingly referred to as "the leader of a team," yet often it is not clear what team he leads, whither it is bound under his leadership, or indeed whether he ought to be the leader. We describe here our initial experience and impressions of teamwork in a rapidly growing community, with a brief forecast of future developments.

The People and the Problems

Andover is a London overspill town, and for the past four years has taken 1,000 persons per annum to live in new council house estates. New factories have been built, and the families are mainly those of young married men who are semi-skilled. Some key workers near to retirement have moved with their firms, but they form only a small minority. Most have their parents and relatives still living in London or in other overspill towns, and family patterns are thus disturbed.

Many families are offered work and a home because they have high social or medical priority; individuals tend to belong to large families, and many hold disablement cards. Before arrival the borough council tries to make sure that each family is free of debt, but this does not exclude the arrival of many "problem families." Indeed, financial crises frequently arise because of higher rent or expensive gas-fired warm-air central heating, too many hire purchase debts, lack of cheap street markets, and the cutting of overtime, if not outright loss of a job. Because of these pressures about 10% of the new families move back to London, often after only a few months in Andover.

The Team

Three years ago we opened temporary practice premises close to the housing and industrial estates. This was done as a development from a single-handed rural practice already operating from purpose-designed premises with full ancillary staff (Evans, 1954). We are now a group of three partners, who in addition to the traditional curative role of the family doctor are fully involved with industrial work, family planning, and infant welfare clinics, together with school medical examinations for nearly all the children in the practice. The ancillary staff includes two nurses, two receptionists, a secretary, and an administrator. All consultations except emergencies are by appointment. A local hospital with 32 beds, admitting general and maternity patients under our direct care, has visiting con-

sultants for outpatient sessions and open access to pathological and x-ray facilities. The nearest acute district hospital is 15 miles (24 km.) away in Winchester.

From the earliest days our attached health visitor has had her office in our building, and makes full use of our reception and clerical staff. She has access to our records (which are filed in "family folders") and runs the infant welfare clinic in part of the premises for three half-day sessions per week. At the same time a district midwife and a district nurse were attached: the midwife has twice-weekly and the nurse has daily sessions at our premises, and their appointments are booked by our receptionist. Their home-visiting and travelling times are thereby reduced, and our liaison with both is greatly helped.

Initially it had been our policy to refer most of our social, welfare, and to some extent psychiatric problems to our health visitor, since we saw her daily and could ask her for information about work done by other welfare workers. It was soon clear, however, that we lacked the appropriate organization for dealing adequately with the whole patient fully related to his social, family, and financial background. We therefore began to hold weekly case conferences attended by the doctors, the health visitor, mental welfare and child care officers, and two welfare officers, all of whom had been allocated by the Hampshire County Council to the Andover area. The psychiatric social worker attends as often as she can. We felt that these conferences would provide the easiest and quickest means of exchanging important and often confidential information and should enable us to decide rapidly on appropriate action. As expected they have proved of great value to all concerned. Facts are quickly and easily produced and not lost in administrative processes. There is less duplication of work and decisions are more single-minded and purposeful.

Typical Case Histories

The following case histories illustrate typical problems. Some details have been altered to preserve anonymity.

Mr. White is a semi-skilled welder, but was an amateur children's conjurer, and recently turned professional. This led to rent arrears and gas and electricity debts. After the birth of their third child recently *Mrs. White* developed puerperal depression and can no longer cope. *Action*: We attempted to persuade *Mr. White* to resume his old trade, since he lacks the skill to become a professional entertainer. The authorities agreed to delay repayment of his debts, and aid has been obtained from both statutory and voluntary sources. *Mrs. White* has been fitted with an intrauterine contraceptive device (I.U.C.D.) financed by charity. The depression has been treated medically and aftercare supervised by the mental welfare officer. The health visitor found a child minder to reduce the mother's burden.

Mr. Black is a lorry driver. He has had innumerable convictions for driving offences, and was finally disqualified from driving. As his work was unsatisfactory in any case, he lost his job. It then transpired that he had paid no rent for a six-month tenancy, had paid no bills, and had several motoring fines unpaid totalling £150,

so that one court was seeking to imprison him for non-payment. He has been married four years, and there are five children. *Action*: All the courts were persuaded to make a single consolidated order for repayment. We found that Mr. Black had failed to claim a large income tax rebate, which met a few of his debts. Close supervision has kept the family intact, not evicted, and with the children still in their parents' care. We found a job for Mr. Black—and he lost it. Mrs. Black had an I.U.C.D. inserted, again by charity.

Mrs. Grey became depressed after the birth of her first child, but broke down completely after the second. She is now thought to be schizophrenic. Her husband, a bricklayer, often works away from home. *Action*: After inpatient treatment Mrs. Grey is being visited at home by the mental welfare officer and the health visitor. The children have been placed with a daily child-minder, and the mother goes to follow-up social facilities. So far no local job has been found for Mr. Grey; his wife has declined an I.U.C.D. and is taking contraceptive pills, supervised by her husband.

Mr. Brown has gross bronchiectasis, and in spite of being registered as disabled he loses jobs with astonishing rapidity. His earning capacity rarely exceeds £13 per week, but unfortunately he and his family can never spend less than £15 per week. To redress the balance they intermittently stop paying the rent. When the housing authority starts to press him, Mr. Brown visits the doctor with depression and productive cough which are improved only by the administration of National Assistance (supplementary benefits). Frequent supervision seems to be helping to break the cycle.

Mr. Green left his wife a year ago with three young children. There are now four. He also left her with many debts. She has no idea of personal hygiene, and the house and children are infested with lice. *Action*: Mrs. Green's irregular periods have been regulated by cyclical administration of proprietary oestrogen/progestogen compound. Apart from this we have had little success, but continue to visit and support. The daily help we found for her left in despair.

Mrs. Cream is an epileptic with gross personality defects. Her husband is an inadequate psychopath and borders on being a mental defective. They can never manage their financial affairs successfully, and therefore both dread another pregnancy. Mrs. Cream also fears another labour because she once had an easy forceps delivery which left unaccountable mental trauma. There is consequent sexual discord. *Action*: The welfare officer after many months of endeavour has at last got their finances straight. We now await the next financial misadventure. Mrs. Cream takes "the pill" with obsessional care, and the children, now that they are hit less often, are becoming more manageable, and attend a play-school for maladjusted children run by the psychiatric social worker.

Mr. Buff is employed as a factory sweeper because he has never learned any trade. Unfortunately he has osteoarthritis of both hips, and his already poor work record is worsening. This causes friction at work. At home he overcompensates by sexual excesses on his fragile woebegone wife. She has become unable to cope through worrying about this and they are in debt. The children misbehave and thus cause more family friction. *Action*: Mr. Buff proved educationally unsuitable for industrial retraining. The wife has been assisted by the administration of "the pill." Help with debts has been obtained and the wife thereby convinced that she can manage on the money available. Two children have been placed in the same school for maladjusted children, and Mrs. Buff is at present not going back to mother. The situation is in unstable equilibrium.

The Scarlets' first child has a severe speech and language disorder, and probably in consequence has had temper tantrums. He was at one time thought to be psychotic. The second child is a mongol. The third child was normal in infancy, but is reacting poorly to this environment and is quite unmanageable. This family causes much marital strain for the parents—the mother has several convictions for petty offences, mainly shoplifting, but has not been in trouble since coming to Andover. *Action*: Accurate and detailed assessment was necessary for the oldest child. We now hope that he may eventually be suitable for special education. At present all three children are attending the school for maladjusted children. Once a year their parents go for a holiday for two weeks and the children are given residential accommodation for this time.

The Pinks. There is nothing wrong with Mr. Pink except that he does not like work. Consequently he tries to get himself injured, goes off sick, and loses his job, whereafter he blames everybody else. His wife quarrels with him incessantly on the subject, and then gets beaten up. She then beats up the child, who has become unmanage-

able. They are in persistent debt. Both have threatened to divorce each other. *Action*: We keep finding Mr. Pink employment. We offer the wife treatment at regular intervals for her anxiety, but as regularly she defaults. The unmanageable child also requires sedation from time to time. The welfare officer helps with debts, whereafter they declare that they can manage. Three months later they prove that they cannot and he has to step in again. Divorce has not been raised recently.

The Rubys. Previous to his marriage Mr. Ruby had a conviction for a homosexual offence, and his wife knew this. Nevertheless they married, failed to succeed in marriage, and divorced. Mrs. Ruby became depressed and made a determined attempt at suicide. She will, we suspect, remain perpetually under treatment. Her husband pays maintenance sporadically, and shows no interest apart from occasional demands through his solicitor to see their one child. Mrs. Ruby has twice moved house to avoid this. She is always in debt. *Action*: Mr. Ruby has now left the district and cannot at present be traced. This enables Mrs. Ruby to obtain state support for herself and the child on which they just exist. The welfare officer advises her financially, and the mental welfare officer also sees her from time to time in case the depression should recur.

Inevitably there are still many families with problems highly resistant to solution, and this now is frequently because the services we would like to call on are as yet undeveloped in our area. Thus we have at present no nursery schools or play groups (other than psychiatric) and far too few registered child-minders. There are inadequate facilities for retraining problem families, and the whole question of appropriate health education is for the most part unsolved.

The Future

The Seeborn Committee recommended that a unified department of social service be created in each local authority, to include the work now done by children's departments, welfare officers, education welfare and child guidance services, mental health social workers, and the home-help service. The workers in such a department would need to co-operate closely with general practitioners in order to be fully effective, and indeed Seeborn suggests that experiments be started now to find the best way of obtaining satisfactory joint working. "Attachment" of social service workers to a health centre or group practice is also proposed, but this implicit suggestion that the doctor shall direct their work may be unacceptable to many social service workers. We would prefer "secondment" and would ensure that this was to be a coequal partnership rather than an essay in empire-building. If the doctor is to be the leader of such a team he should qualify by his talents for leadership rather than by his possession of a medical degree.

Locally we are seeking closer contact with the probation service, and in our new premises we shall be able to offer office space to a social welfare worker. This seems to us logical, since patients in need will then obtain medical and social help in the same building and often at the same time.

It has been suggested (Jameson, 1956; Seeborn, 1968) that health visitors should be limited to "detecting needs" for the welfare services. We feel that this would be a gross waste of their training and of their experience in dealing with problems directly.

Something remains to be said about the role of the doctor himself. Sitting-in at a case conference for the first time one could be forgiven for feeling that one had come to the wrong meeting—this surely is a committee for handling social misfits and delinquents; for restoring order in disorder. Where indeed is the family doctor, and should he be leading this team? But this is indeed a family doctor's case conference. From it, of course, is excluded a large proportion of the doctor's clinical work—work which carries its quota of social complications but which in these cases the doctor is able to manage in the light of his own personal knowledge and experience. At this conference we deal with the primary and often the long-term care

of patients whose problems typically may have minimal medical content. Purely medical advice and treatment can do little more than scratch the itchy surface of their dis-ease.

We believe that it is part of the family doctor's life to discover these patients. Their recovery demands resources far beyond his individual scope. Here is the need for teamwork. Individual members of the team are there not only to present their own problems but especially to operate joint machinery for recovery. Where such machinery does not exist then they

must improvise until the need for it is clearly recognized, when they must take an active part in its invention.

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CONFERENCES AND MEETINGS

Second Caribbean Cancer Congress

[FROM A SPECIAL CORRESPONDENT]

The Second Caribbean Cancer Congress was held between 24 and 27 November at the University of the West Indies, Kingston, Jamaica. Seven symposia were held on modern aspects of cancer, while a number of original papers were also read.

Causes of Cancer

At the first symposium, on the "Aetiology of Cancer," Dr. J. GRACE (Rosewell Park Memorial Hospital, New York, U.S.A.) said that viral carcinogenesis was general throughout the animal kingdom up to and including primates, though in man the evidence was only circumstantial. In tissue taken from patients with Burkitt's lymphoma Dr. Grace had found a virus morphologically resembling the herpes group. Less than 5% of cells contained the virus, which had nevertheless been isolated 200 times from 350 cell lines. Having made a virus-specific fluorescent antibody and using electron microscopy, he had visualized the virus on the cell surface, in the cytoplasm, and penetrating the nucleus. Concluding, Dr. Grace suggested that the body could respond to the virus without clinical manifestations, by a reversible process seen as infectious mononucleosis, or, rarely, by an irreversible malignant process.

Taking an opposite point of view, Dr. E. WYNDER (Sloan Kettering Institute, New York, U.S.A.) considered that 80% of cancer was due to environmental factors, which could be controlled long before the mechanisms were understood. In 1945 male cancer incidence in the U.S. had been less than female, but in 1968 it was more, owing to the epidemic of cancer of the lung. Epidermoid cancer now accounted for 35.9% of male cancers, but only 18.0% of females, and this type of cancer was nearly always related to irritation. One-quarter of malignancies in males were related to smoking, including those of lung, oral cavity, and bladder. Epidemiological studies had also shown the relation of upper intestinal tract carcinomata to chronic iron deficiency in women with Plummer-Vinson syndrome; and increased incidence of cervical cancer

with number of marriages and lower age of first coitus, but not to circumcision of the male. The influences of smegma and of vitamin A deficiency were at present being investigated. Dr. Wynder was opposed to genetic influences playing much part, as patients from a low-risk area for a particular tumour—such as carcinoma of the colon in Japan—tended to develop the higher risk of the local population when they moved to Hawaii or California, and vice versa. Such geographical differences were more likely to be environmental. Similarly the incidence of stomach cancer was falling throughout the world, probably related to better diet, while that of cancer of the colon was rising.

Carcinoma of Oesophagus

Dr. E. J. BEATTIE (Memorial Hospital for Cancer, N.Y., U.S.A.) said that oesophageal cancer had only a 3% five-year survival rate. Of 1,859 cases seen at his hospital between 1926 and 1966, 192 were in the cervical oesophagus, while 1,543 had been epidermoid in type. Of patients treated surgically 7 out of 164 had survived the earlier operation of oesophagectomy and oesophagogastronomy for five years, while 4 of 31 had survived oesophagectomy with delayed colon transplant, giving an overall five-year survival rate for surgery of 19%. Dr. Beattie showed a film of the technique of the colon bypass operation, and mentioned one case in which a subsequent carcinoma of the transplanted colon had been successfully resected. Dr. VIVIAN BROOKS (Kingston, Jamaica) had operated on 12 patients with carcinoma of the oesophagus classified as inoperable. The colon bypass technique was used leaving the affected oesophagus behind. All survived the operation, with cure of their dysphagia and improvement in nutrition, but six had needed further surgery for wound abscesses, redundant colon, and necrosis of the colon. Eleven lived an average of 10 months and one had survived for four and a half years.

Reviewing radiotherapy for oesophageal cancer Dr. K. ARTHUR (Kingston Public Hospital, Jamaica) said that of 64 patients treated since 1963 overall less than 20% had

survived one year. Nevertheless, after the introduction of a megavolt cobalt unit in 1964 and fixed field therapy in 1965, 35% had survived one year.

Cancer Prevention

The third symposium, on "Cancer Prevention" was introduced by Dr. R. W. RAVEN (Royal Marsden Hospital, London), who said that a new approach to the inscrutable problem was essential because 90% of cases could be prevented. What was required was new organization, new institutes, and the recognition and application of new knowledge, with better liaison between the public, the research worker, and the hospital doctor. He concluded that the future was bright.

Dr. J. RHODES (University of Pennsylvania, U.S.A.), discussing the statistical approach, said that the distance one could go in preventive surgery in any particular cancer depended on the "loss" (the product of the operative mortality and the incidence of innocent lesions) being less than the "gain" (the product of the cancer incidence and the survival after preventive surgery after deduction of the survival rate after therapeutic surgery). Applying this formula to surgery for gastric ulcer to reported series, Dr. Rhodes showed a two-to-one gain for preventive surgery; a seven-to-one gain for preventive surgery for nodular goitre; and a three-to-one gain for removal of the stone-containing gall bladder.

In the symposium on cancer of the cervix Professor J. REAGAN (Western Reserve University, Cleveland, Ohio, U.S.A.) remarked on the changing pattern of uterine cancer. The overall incidence was rising, but in 1945–8 the figures for cervical cancer were: in-situ 2%, and invasive 98% (stages 1 and 2 41%, 3 and 4 59%). In 1961–4 the respective figures were 45% and 55% (88% and 12%). Whereas in 1943–7 the different histological types had been large-cell 35%, keratinizing 40%, small-cell 18%, and others 7%, in 1963–7 the respective proportions were 60%, 15%, 5%, and 20%. Nevertheless, the prognosis was worst with the last two histological groups, which in both series had accounted for 25%.