Social work in general practice

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SUMMARY. A questionnaire seeking details of working arrangements and problems encountered was circulated to social workers working in general practice.

The main difficulties were: insufficient preparation for the scheme, poor communication between general practitioners and social workers, and the inadequate provision of facilities for social workers in practice premises.

Most of the respondents had not experienced big difficulties. Two thirds had enjoyed a rewarding professional experience, which is a testimonial to interdisciplinary co-operation.

Introduction

THERE has been increasing interest in recent years in social workers and general practitioners working together, and several studies have been published describing early co-operative schemes (Forman and Fairbairn, 1968; Goldberg and Neill, 1972). Many social workers and general practitioners are probably working in relative isolation and little is known about how widespread co-operative schemes are. Ratoff and colleagues reported in 1973 but since then there have been further developments.

Aim

One aim of the General Practitioner and Social Worker Workshop is to act as a 'clearing house' for such information, and where information does not exist, to seek it. As little has been published on the current extent of social work in general practice, we tried to assess this, examining the type of work done by the social workers, their mode of working, and the problems they encountered.

Method

A questionnaire was drawn up under three sections: Organization and Logistics, Structured opinion, and Unstructured opinion.

In 1976 a letter was sent to the principal officer responsible for health services liaison in each social services department in Great Britain, asking for the names and addresses of social workers involved in co-operative schemes with general practitioners. Reminder letters were sent out later to those departments who did not reply initially. Individual social workers were then sent a questionnaire about their work in general practice and asked to return it in the stamped addressed envelope which was enclosed.

A few departments refused to divulge the names and addresses of individual social workers and in these cases, the questionnaires had to be distributed through the social services department concerned. Although the total number of questionnaires sent to these departments is known, we have no means of knowing how many were actually distributed to social workers, and to what extent some departments may have over ordered copies of the questionnaire. Reminders and further questionnaires were sent to those of the first 100 social workers who had not replied to the first questionnaire after three months. Owing to the limitations of time, reminders could not be sent to the other social workers. The completed questionnaires were analysed and the results tabulated.

Results

Four hundred and twenty questionnaires were distri-

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Table 1. Number of local authorities having social work schemes*.

	With schemes		Without schemes		Ambiguous replies	No reply	Total
	Number	Percentage	Number	Percentage			
Metropolitan districts	16	*44.4*	18	*50.0*	0	2	36
Counties							
—England	26	*66.7*	9	*23.1*	1	3	39
—Wales	3	*37.5*	2	*25.0*	1	2	8
London boroughs	14	*42.4*	18	*54.5*	0	1	33
Scottish regions	6	*50.0*	3	*25.0*	1	2	12
Total	65	*50.8*	50	*39.1*	3	10	128

*This classification is the same as that adopted by the Association of Directors of Social Services in the booklet *Directory of Local Authority Social Services Departments* (1975).

buted: 219 questionnaires were available for analysis, some of which were only partially completed. In some sections, social workers provided additional answers relating to two places of work and so some answers total more than 219.

The response rate was 52·1 per cent. As explained above, however, some social workers who received a questionnaire may have been overestimated by the system of sending a batch of questionnaires to some authorities. Of the 285 questionnaires posted to *individual* social workers, 181 were returned—a response rate of 63·5 per cent.

Table 1 summarizes the number of local authorities with schemes: over half the departments in Great Britain have organized links with general practitioners.

Section A: Organization and Logistics

The first part of the questionnaire dealt with the organization and logistics of the co-operation scheme, under seven headings.

1. Initiation of the scheme

Question i) When did the scheme start? (Answers given in Table 2.)

Question ii) When did you start work in the scheme? (Answers given in Table 3.)

Half the schemes have started since the end of 1973, and half the social workers have been working in them since the end of 1974.

Table 2. Initiation of the scheme.

	1960s	1970	1971	1972	1973	1974	1975	1976	No answer
Number	8	4	9	17	34	41	66	15	25
Per cent	*3.7*	*1.8*	*4.1*	*7.8*	*15.5*	*18.7*	*30.1*	*6.9*	*11.4*

Table 3. Number of social workers in the scheme.

	1960s	1970	1971	1972	1973	1974	1975	1976	No answer
Number	4	—	2	5	18	47	104	26	13
Per cent	*1.8*	—	*0.9*	*2.3*	*8.2*	*21.5*	*47.5*	*11.9*	*5.9*

Question iii) What type of scheme is it? (Table 4).

Table 4. Type of scheme.

	Number	Per cent
Permanent	135	*61.6*
Experimental—definite limited period	4	*1.8*
Experimental—to be reviewed in light of progress	59	*26.9*
Other	12	*5.5*
No answer	9	*4.1*

2. Logistics

Question i) How many hours per week do you spend working in general practice?
There were 190 valid answers; 29 did not reply. The range was from 0 to 37·5 hours; the mean was 4·59 hours; standard deviation 7·70 hours. The median time was two hours.

Question ii) How many hours per week do you spend working in settings other than general practice?
There were 177 valid answers; 42 did not reply. The range was from 0 to 60 hours; the mean was 31·39 hours; standard deviation 10·94 hours. The median time was 35·5 hours.

From the facts given above, it can be seen that the majority of social workers are full time, devoting only a small part of their working week to general practice. The sum of the two median times exactly equals the standard working week. The sum of the mean is slightly smaller and can perhaps be accounted for by the relatively small number of social workers working exclusively part time in general practice. There seem to be three or four groups of social workers (in this context):

Table 5. Other settings in which the social workers worked.

	Number	Per cent
Social services department	160	*73.1*
None	10	*4.6*
Hospital social work team	9	*4.1*
Other	9	*4.1*
No answer	31	*14.2*
Total	219	*100*

1. Full time in general practice.
2. Part time exclusive in general practice.
3. Session in general practice, bulk of work elsewhere—'attachment' social workers.
4. Liaison only—no clients seen in general practice, but communication between general practitioner and social worker.

There is naturally some overlap between groups. The other defined settings in which the social workers worked are shown in Table 5.

There is some evidence that different types of local authorities have different types of schemes (Table 6).

When Metropolitan districts and London boroughs, representing the conurbation authorities, are compared with the urban and rural English and Welsh counties and Scottish regions, the difference between the numbers of social workers in sessional and in liaison attachments is statistically significant: $\chi^2 = 14 \cdot 64$, d.f. = 1, $p < 0.001$.

Question iii) How many doctors work in the general-practice centre(s) in which you work? (Table 7).

Table 6. Social work schemes.

	Full time in general practice	Part time in general practice, but no other work	Part time in general practice, main work elsewhere	Liaison only	Unclassified because of overlap of groups
Metropolitan districts	—	—	26	4	2
Counties					
—England	2	1	39	59	18
—Wales	—	—	5	2	1
London boroughs	—	1	15	9	2
Scottish regions	—	1	7	6	3
Not known	4	3	7	2	0
Total	6	6	99	82	26

Table 7. Number of doctors working in the general-practice centre(s).

Number of doctors	Number of general-practice centres	Per cent
1	5	*2.3*
2	24	*11.0*
3	32	*14.6*
4	39	*17.8*
5	33	*15.1*
6	27	*12.3*
7	14	*6.4*
8	8	*3.7*
9	5	*2.3*
10	5	*2.3*
11-20	11	*5.0*
>20	1	*0.5*
No answer	15	*6.9*

Question iv) Do you work with all the doctors in the centre?

One hundred and eighty-seven (85·4 per cent) social workers worked with all doctors in the group; 20 (9·1 per cent) did not work with all doctors in the group; 12 (5·5 per cent) did not answer.

Comparison with the tables published by the DHSS (1975) shows that there is under-representation of single-handed, and over-representation of groups of six or more practitioners in the study, compared with national figures.

Question v) Do your responsibilities in social work outside general practice include working in any other situations? (Table 8).

Table 8. Other situations involving social work responsibilities outside general practice (percentages in brackets).

	Yes	No	Not applicable
Intake team	55 *(25.1)*	87 *(39.7)*	77 *(35.2)*
Long-term team	112 *(51.1)*	43 *(19.6)*	64 *(29.2)*
Hospital team	12 *(5.5)*	114 *(52.1)*	93 *(42.5)*
Situation other than above	70 *(32.0)*	62 *(28.3)*	87 *(39.7)*

Forty-nine specified that they were generic social workers in an area team.

Table 9a. Presence of a room used solely by a social worker at the general practice.

	Yes	No	Not applicable
Number	44	167	10
Per cent	*19.9*	*75.6*	*4.5*

In this question there were 221 possible answers as two respondents answered twice in respect of different general practices in which they worked.

Table 9b. Room arrangements for the social worker at the general practice.

	Number	Per cent
Spare surgery	49	*29.3*
Records room	1	*0.6*
Other room (shared)	40	*24.0*
Room (unspecified)	15	*9.0*
No answer	62	*37.1*
Total	167	*100*

3. Organization within practice

Question i) Do the practice premises include a room which is solely for the use of a social worker? (Table 9a).

Those giving no as the answer to this question were asked to specify the room arrangements at the general practice (Table 9b).

Question ii) In the room you most commonly use is there a telephone available? (Table 10a).

Those giving no as the answer to this question were asked if a practice telephone was available for their use (Table 10b).

Table 10a. Availability of telephone in room most commonly used.

	Yes	No	Not applicable
Number	149	39	31
Per cent	*68*	*17.8*	*14.2*

Table 10b. Availability of a practice telephone.

	Yes	No
Number	34	7
Per cent	*82.9*	*17.1*

Thirty-nine answering no, and two answering not applicable to question (ii), gave responses to this question (total 41).

Table 11. Provision of secretarial help in the practice.

	Yes	No	Not applicable
Number	46	145	28
Per cent	*21*	*66.2*	*12.8*

Secretarial help provided by:	Number	Per cent
—the practice	33	*71.7*
—local authority	8	*17.4*
—area health authority	1	*2.2*
—the practice/local authority	1	*2.2*
No answer	3	*6.5*
Total	46	*100*

Table 12. Provision of secretarial help in premises other than the practice.

	Yes	No	Not applicable
Number	163	35	21
Per cent	*74.4*	*16.0*	*9.6*

Table 13a. Use of practice receptionists in the making of appointments.

	Yes	No	Not applicable
Number	78	119	23
Per cent	*35.4*	*54.1*	*10.4*

One person answered twice for the two practices he works in.

Table 13b. How appointments are made.

	Number	Per cent
Via area office	33	*28*
By social worker	29	*24.6*
Referred by general practitioner or other member of team (e.g. health visitor, district nurse) and visited at home	20	*17*
Liaison only	20	*17*
No answer	13	*11*
Separate receptionists for social workers in health centre	2	*1.7*
Message written in memo book	1	*0.9*

Table 14. Areas in which financial assistance is provided by the local authority.

	Number answering yes	Per cent
Accommodation	14	*6.4*
Use of telephone	14	*6.4*
Secretarial assistance	10	*4.6*
Local authority premises used	5	*2.3*

These responses should be compared with the responses to questions 3(i) and 3(v) which detail the services available to the social worker.

Question iii) Is secretarial help provided in the practice premises and if so by whom? (Table 11).

Question iv) Is secretarial help provided for you in premises other than the practice? (Table 12).

Question v) Are the practice receptionists used to make appointments for your clients? (Table 13a).
Those giving no as the answer to this question were asked to provide details for the making of appointments (Table 13b).

Question vi) Does the local authority assist the practice financially? (Areas of financial assistance listed in Table 14).

4. Communication

Question i) Do you record directly onto NHS records?

Question ii) Are reports from you included regularly in the NHS records?

Question iii) Do members of the practice send requests (or reports that you include in your records)?

Table 15. Communication between social workers and members of the practice (figures given as percentages).

	Yes	No	Not applicable
i) Direct recording onto NHS records	*6*	*90.8*	*3.2*
ii) Regular inclusion of reports in NHS records	*20.2*	*74.3*	*5.5*
iii) Requests (or reports) from practice members	*75.2*	*20.6*	*4.1*
iv) Regular meetings with practice staff	*65.6*	*30.7*	*3.2*

Table 16. Percentage of social workers meeting with doctors and other workers.

Social workers meeting with:	
—several doctors	33.3
—doctors and other workers	29.2
—one doctor	5

The number of social workers working exclusively in general practice is too small to allow statistical evaluation.

Question iv) Are regular meetings with the practice staff included in your weekly timetable?

The results are given in Table 15.

Those social workers who do meet regularly with practice staff were asked to provide details of the number of staff with whom they have meetings (Table 16).

There is no statistically significant difference between the sessional and liaison groups in respect of parts (i) and (ii) of this question. However, there is a statistically significant difference between these groups in parts (iii) and (iv). Social workers with a sessional attachment were more likely to receive requests or reports that they included in their own records ($\chi^2 = 8 \cdot 06$, $p < 0 \cdot 005$) and to have regular meetings with the practice staff ($\chi^2 = 11 \cdot 25$, $p < 0 \cdot 001$) than social workers with a liaison scheme.

5. *Social work aspects*

Question i) Do you accept referrals from the following? The figures given are percentages of social workers answering yes.

Doctors	97.3
Health visitors	90.4
District nurses	81.7
Direct from client	70.3
Others: ranging from police, DHSS, neighbours, schools and so on	44.4

Question ii) The following is a list of the types of referral that you might have been asked to deal with. Could you please tick those types of referral that you have actually received while working in your present attachment. Answers are given as percentages answering yes:

Provision of appliances for the physically handicapped (other than the deaf and the blind)	83.6
Provision of services for:	
—the deaf	35.2
—the blind	55.3
(In some instances the social worker accepted referral but passed it on to a specialist worker.)	
Advice about social benefits (for example, money)	83.1
Obtaining accommodation for clients (for example, rehousing, part III for elderly)	90.0

Table 17. Qualification and background of the social workers.

	Percentage of social workers
Qualification:	
—qualified	83.9
—unqualified	12.4
—no answer	3.7
Background:	
—welfare assistant grade	0.9
—basic grade	59.6
—senior grade	27.1
—other grades, ranging from trainees to assistant team leaders	9.2
—no answer	3.2

Assisting the client with problems arising from:	
—marital conflict	87.7
—marital separation	80.4
—contact with the law	51.6
—conflict with parents	75.8
—other reasons	76.3
For assistance with management of psychiatric illness:	
—psychotic illness (for example, schizophrenia, manic depressive illness)	73.1
—other psychiatric illnesses (for example, neurotic depression, anxiety, psychosomatic illness)	84.0

6. *Use of statutory powers*

When based in general practice are you able to use statutory powers (for example, under the Mental Health Act)? The percentage answering yes to this question was 60·7 per cent.

7. *Qualification and background*

The qualification and background of the social workers are given in Table 17.

All social workers working full time, or exclusively part time, were qualified. Of those working on a sessional basis, 81·8 per cent were qualified, 15·2 per cent were unqualified, and 3·0 per cent did not answer. Of those who had a liaison arrangement, 86·6 per cent were qualified, 12·2 per cent were unqualified, and 1·2 per cent did not answer.

There is no statistically significant difference between the sessional and liaison groups in respect of the different grades in which the social workers are employed, nor in respect of the numbers qualified and unqualified.

Section B: Structured opinion about problems in attachments

This section of the questionnaire considered factors that might cause problems in co-operative schemes between social work and general practice. In order to simplify the completion of the questionnaire a list of 12 potential problems was drawn up. Respondents were asked to list the problems that had actually occurred in their scheme. They were also given the opportunity to rate the severity of each problem. The problem list was compiled by the authors on the basis of experience, but space was included so that the respondent could add problems not mentioned on the list. The 12 problems were:

1. Inadequate provision of accommodation for the social worker.
2. Inadequate provision of services, for example, telephone, secretaries, and so on.
3. Lack of preliminary discussion between attached social worker and social work seniors about the attachment.
4. Lack of preliminary discussion between the social work agency (or social worker) and the practice team about the attachment.
5. Absence of regular structured meetings between doctors and social workers to discuss clients' problems.
6. Inadequate provision of opportunity for informal discussion about patients' problems.
7. Absence of regular channels of communication with the practice so that problems arising in the attachment may be discussed.
8. Absence of procedure for regular written communication about clients' problems.
9. The absence of channels of communication with the senior staff in the social work agency so that problems arising in the attachment may be discussed.
10. The referral to the social worker of problems that prove professionally unsatisfying.
11. The impairment of communication by the problems of language (social workers and doctors use language differently and each have a technical jargon of their own).
12. That the personalities involved in the attachment are incompatible.

Results

Problems were rated as occurring in 170 schemes. The majority of respondents confined themselves to the problems defined in the list; no respondent added more than one further problem to the list.

Frequency of problems in schemes

A histogram has been prepared to show the distribution of problems within the schemes (Figure 1). The majority had three or fewer problems, and a minority had a large number of problems (six or more). The total number of schemes was 170; the total number of problems was 697, and so the average number of problems per scheme was 4·1.

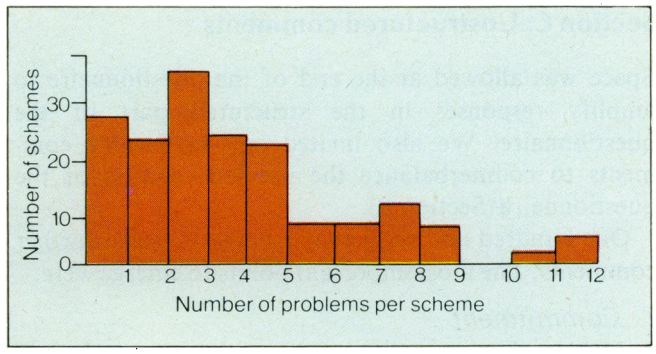


Figure 1. *Distribution of problems in the schemes.*

Types of problems in schemes

A histogram has been constructed to show the distribution of types of problem (Figure 2). The three most common problems were lack of preliminary discussion, lack of regular structured meetings, and referral of problems that are professionally unsatisfying to the social worker.

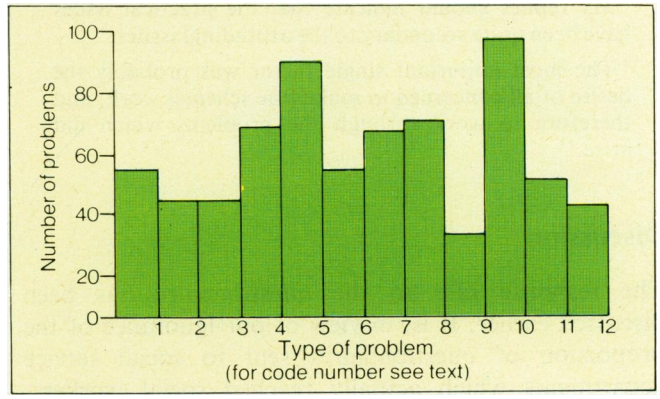
Severity of problems

Scrutiny of the ratings showed that there were three categories of severity of problem. These are shown in Table 18 (the more severe the problem, the greater the number of asterisks).

Table 18. Severity of problem.

Severity	Problem number
*	8, 9, 10, 11, 12
**	1, 2, 3, 7
***	4, 5, 6

Figure 2. *Distribution of type of problem.*



Section C: Unstructured comments

Space was allowed at the end of the questionnaire to amplify responses in the structured part of the questionnaire. We also invited any favourable comments to counterbalance the previous section of the questionnaire (Section B).

One hundred and sixty people chose to make further comments. The most important points to emerge were:

1. Commitment

A high level of commitment by social service departments, management, field workers, and general practitioners is essential for the success of the scheme. This implies that social service management have given a degree of priority in their allocation of resources.

2. Adequate preparation

Many respondents stressed that the success of their scheme owed much to adequate preparation by all levels in the social services department and the general practitioners before the scheme started. Lack of suitable preparation can be disastrous.

3. Choice of social worker

It is necessary to select social workers who, in addition to social work qualifications, have the necessary personal qualities and experience to have a flexible approach in their attitude to medical practice.

4. Communication

There was emphasis on the importance of regular meetings for the discussion of individual cases and general problems within the team—regularity being more important than the length of the meetings. Over one third of the respondents indicated that there had been an improvement in communication and understanding with the general practitioner and other members of the team.

About one third of the replies commented on the growth of knowledge and understanding of each other's roles and responsibilities as a result of working together.

5. Attitudes

It seemed that the difficult and less tangible area of attitudes is crucial to the success or failure of attachment and liaison schemes. Two comments illustrate this very well:

> "My replies should indicate that the practical issues have been quite secondary to the attitudinal issues."

> "The most important single factor was probably the desire of all concerned to make [the scheme] work, and therefore to work through the problems which did arise."

Discussion

The response rate to the questionnaire has been discussed earlier. It is, in view of our ignorance of the proportion of questionnaires sent to social service departments which actually reached social workers, impossible to provide an accurate estimate, but it falls within the range of 52 to 63 per cent, and is probably nearer the latter.

We use the term 'attachment' to refer to those schemes where social workers see clients in general-practice premises, be they health centres, group practice premises, or traditional surgeries. When social workers relate to particular general practitioners and accept referrals from the practice, but do not actually see clients in the practice premises, they are described as participating in liaison schemes.

The replies to the first part of the questionnaire reveal that just over half the social service departments in Great Britain are involved in schemes of either type, two thirds of which had started since the end of 1973. Eighty per cent of the respondent social workers started to work in their schemes after that date, which appears to mark a watershed in the relationship between social work and general practice, following the implementation of the Seebohm report. Since the beginning of 1974 the number of attachment and liaison schemes has considerably increased.

Because of differing methods it is difficult to compare the results of this part of the questionnaire with the findings of the survey conducted in 1972 by Ratoff and colleagues. Their data were obtained from directors of social service departments and their enquiries related to attachment schemes only—liaison arrangements remained outside the terms of the study. They discovered that although about 50 per cent of social service departments operated medical attachment schemes, they involved only a very small proportion of social workers (1·5 per cent of full-time equivalents), most of whom worked in the hospital services with very few working in general practice.

We found that there is a higher proportion of schemes in the county councils than in the metropolitan boroughs (3:2), but many of the former are liaison arrangements, probably for geographical reasons, since long distances and scattered populations make attachment schemes difficult to administer.

Ratoff and his colleagues had found in their study that Greater London and the South-West had the largest number of social workers attached to general practice, whereas the North, Yorkshire and Wales had the smallest.

In our survey 60 per cent of the schemes were described as permanent, the remainder being experimental—a few for a limited period only, and the majority being subject to periodic review.

Of the 193 social workers who defined their categories, only six worked full time and six part time in general practice attachments, with no other social work commitment. Ninety-nine (45 per cent) spent part of their time in attachments, with their principal social work involvement elsewhere, and 82 (37 per cent) worked in liaison schemes.

Two thirds worked with groups of four or more doctors, either in health centres or general practice

premises, suggesting that doctors practising in groups were more able to make social work help available to their patients than doctors practising alone or in smaller groups.

The answers to the section of the questionnaire concerned with the facilities available to the social worker in the practice premises revealed some disquieting deficiences. In only 20 per cent of the schemes was there a room solely for the use of the social worker; 17 per cent of rooms used had no telephone, and only 21 per cent of social workers had secretarial help in the practice. Practice receptionists made appointments for clients in 35 per cent of the attachment schemes.

We consider that a personal interviewing room is as important to the attached social worker's task as the surgery is to the general practitioner's. We suggest that the following facilities are desirable for the effective operation of social work attachments, and should be negotiated at the initial planning meetings:

1. Interview room.
2. Telephone.
3. Secretarial help.
4. Filing and recording facilities.
5. Receptionists' services.

Social workers in liaison schemes have more modest needs—the minimal requirements being access to a telephone, recording facilities, and the opportunity to discuss clients with doctors.

The replies to the section of the questionnaire on communication revealed that only six per cent of social workers recorded directly into the patient's notes, and that in no more than 20 per cent of cases were social reports inserted in the NHS records. The issue of confidentiality may be raised to account for these disappointing figures, but if shared care is to have meaning, it is necessary to share information in the interest of the patient. Equally disturbing is the revelation that in 30 per cent of replies there were no regular meetings between the social worker and the remainder of the practice staff, including the practitioners. Working under the same roof is not synonymous with working together.

It was gratifying to learn that the majority of social workers accepted referrals from the other members of the primary health care team and from the client directly, and that almost half were prepared to offer help to clients referred from any source in the community.

In an attempt to determine the patterns of work in general practice a list of 12 headings was included in the questionnaire (Section A, question 5(ii)), and the respondents were asked to indicate in which problem areas they had received referrals. Seventy-five per cent had received requests for help in all but three groups; the least common being the provision of services for the deaf and the blind, and contact with the law, which tend to be the more specialized areas, and a number of social workers commented that referrals for the deaf and the blind were dealt with by specialist workers.

Forman and Fairbairn (1968), Cooper (1971) in his report of the Derby scheme, and Goldberg and Neill (1972) have described the range of social and psychological problems encountered by social workers in general practice attachments. Consideration of the replies to this section of the questionnaire, in the light of these accounts, suggests that a degree of uniformity of referral exists whenever social workers treat clients in the *milieu* of general practice.

From the results of Section B of the questionnaire, two of the three most frequently identified difficulties, that is, "lack of preliminary discussion between the social work agency (or social worker) and the practice team about the attachment" (problem four), and "absence of regular structured meetings between doctors and social workers to discuss clients' problems" (problem five), were rated as severe, and the third severe problem, "inadequate provision of opportunity for informal discussion about patients' problems" (problem six), is closely related in content to problem five.

The coincidence between the frequency and severity of problems four and five is highly significant and provides an opportunity to focus on the causes of potential failure of both attachment and liaison schemes, and perhaps to offer some suggestions for methods of prevention of such mishaps.

It is evident that without adequate preliminary discussion, liaison and attachment schemes are likely to founder on rocks which cannot be avoided by good intentions alone. A representative of social services management, the social worker likely to be involved in the scheme, and the general practitioner should participate in preliminary discussions in order to establish the basis of the collaborative relationship between the social workers and the general practitioners. It is suggested that discussions should include the following topics:

1. The types of referrals most appropriate to the skills of a social worker in general practice.
2. The quantity of social work time available to the doctors.
3. Accommodation for the social worker.
4. Access to medical records and type of recording.
5. Secretarial help.
6. Provision of a telephone.

Preliminary agreement about communication is essential for the success of the schemes. Time must be set aside for regular case meetings, in addition to informal discussions about mutual problems as they arise. There may be difficulties in communication in the early stages as a consequence of the different assumptions of each profession, and the different vocabularies used to describe similar problems—the social model may be unfamiliar to general practitioners and the medical

COLLEGE ACCOMMODATION

Charges for college accommodation are reduced for members (i.e. fellows, members and associates). Members of overseas colleges are welcome when rooms are available. All charges for accommodation include breakfast and are subject to VAT. A service charge of 12½ per cent is added. Members are reminded that children under the age of 12 years cannot be admitted and dogs are not allowed. Residents are asked to arrive before 18.30 hours to take up their reservations.

From 1 September 1978, charges are (per night):

	Members	Others
Single room	£5	£12
Double room	£10	£20
Flat 1	£15	£25
Flat 2	£18	£25
Flat 3	£20	£30

Charges are also reduced for members hiring reception rooms compared with outside organizations which apply to hold meetings at the College. All hirings are subject to approval and VAT is added.

	Members	Others
Long room	£40	£80
Damask room	£30	£50
Common room and terrace	£30	£50
Kitchen	£10	£20
Seminar room	£20	£30
Poc room	—	£20

Enquiries should be addressed to:

The Accommodation Secretary,
Royal College of General Practitioners,
14 Princes Gate, Hyde Park,
London SW7 1PU.

Tel: 01-584 6262

Whenever possible bookings should be made well in advance and in writing. Telephone bookings can be accepted only between 9.30 hours and 17.30 hours on Mondays to Fridays. Outside these hours, an Autophone service is available.

model misunderstood or disliked by social workers.

The members of the General Practitioner and Social Worker Workshop believe that the questionnaire has served a useful purpose in discovering the amount of collaboration existing between social workers and general practitioners, and revealing some of the difficulties which have emerged from the attachment and liaison schemes.

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Addendum

Please address all correspondence to Dr Iain C. Gilchrist, Broomfields, Hatfield Heath, Bishop's Stortford, Hertfordshire CM22 7EH.

Relief of uraemic pruritus with ultraviolet phototherapy

We studied the effect of ultraviolet light phototherapy on severe persistent pruritus in 18 adult patients on haemodialysis. Patients were randomly assigned to one of two light sources. The experimental group received conventional sunburn-spectrum light in gradually increasing doses. The control group received time-matched exposures to long-wave ultraviolet light. All patients received eight exposures to the entire skin surface over a four-week treatment period. Nine of ten patients in the sunburn-spectrum group reported marked decrease in pruritus as opposed to two of eight in the placebo group ($p < 0{\cdot}01$). Of those responding to sunburn-spectrum light, improvement usually occurred two to three weeks after the start of treatment. Mild sunburn, noted by some patients in this group, was the only side effect. The response to phototherapy was unaffected by the presence of secondary hyperparathyroidism. Ultraviolet phototherapy is a safe, convenient, inexpensive and effective treatment for uraemic pruritus.

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