Rehabilitation and the general practitioner*

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As a doctor you are involved in the rehabilitation of those suffering from chronic or permanent disabling problems. Rehabilitation is not a specialized technique, not a method, not even a principle but is a philosophy in action. The philosophy of total care of your patient as well as the continuing care for him. The broad aim or goal of rehabilitation is to correct in so far as is possible your patient’s problem (whether it be physical, mental or social) and in addition to continue to help him by treatment, training, education and encouragement to cope with the residual uncorrectable portion of his problem and his attitude toward it in order that his life can be changed from one that is empty to one that is full. In a sense rehabilitation is 'going the second mile', and often further with your patient and it is applicable to the disabling problems of all fields of medicine and surgery. The rehabilitation of patients with disabling disorders of the musculoskeletal system will require and deserve rehabilitation in its broadest sense. The rehabilitation of such patients—the total care of them as well as the continuing care for them cannot be accomplished by one person; indeed the philosophy of rehabilitation requires the co-ordinated efforts of a large group or team of professional persons including the physician or surgeon, who is the captain or co-ordinator, the nurse, the physiotherapist, occupational therapist, orthoptist, prosthetist, psychologist, medical social worker, teacher and vocational adviser. Through continuing advances in all these fields rehabilitation is becoming progressively more realistic and effective and it will be of even greater importance in the future than it has been in the past.

So wrote Robert Salter. In Britain about 1,500,000 persons are found in groups officially described as disabled or handicapped. Over 1,000,000 of these live at home. These figures are from official statistics. Judging from surveys made in Scandinavia and the United States the true figure is more likely to be 3,000,000 or six per cent of the population. The care of these patients and the continuing care for them is very largely undertaken by the general practitioners of this country. The physical, mental and social problems of this group are mainly solved by the individual general practitioner who, furthermore, makes the major, and usually only, contribution towards encouraging his patient to cope with his residual disability.

Rehabilitation implies an involvement with the totality of the individual and his problems. It implies a cutting across the specialist diagnostic barriers by a generalist sometimes using specialist advice and facilities. It must be recognized that today's family physician is one who is trained and experienced in assuming a responsibility for primary and continuing medical care on a comprehensive basis to all members of the family using the ancillary and consultative facilities available to him. Britain has maintained a system of domiciliary care for the patient in his own home that is becoming as rare in Western Society as the monarchy, and yet which, because of its personal and independent nature, contributes materially to the social, emotional and physical security of the individual patient and his family. There are many advantages to the place of the independent-contractor general-practitioner free of many of the bureaucratic shackles of hospital practice, but one sad result has been a divorce of the general practitioner from the hospital and public health teams of patient management and leaves the British general practitioner in many instances as an inadequate, overtrained and under-utilized appendage to one of the best systems of comprehensive medical care in the world today.

I will consider later some of the problems of the situation, first let us consider what

* A lecture given on 24 October 1968 at the Royal National Orthopaedic Hospital.

J. ROY. COLL. GEN. PRACTIT., 1969, 17, 292
the general practitioner is doing in rehabilitation. For centuries, before physical medicine was ever thought of, the general practitioner has been handling the multitude of family, physical and mental problems surrounding chronic disability by practising the art of patient handling and by giving advice on attitudes and aptitudes, on aids and facilities. He manages, in 90 per cent of all cases in the community, the therapy of chronic ill-health and its intercurrent complications.

The family doctor is the adviser and link-man between the patient and the multitude of official and voluntary, hospital and local authority services. This link is often tenuous for within the setting up of these services the general practitioner has no place. I found it interesting in reading the official handbook—*Rehabilitation services for the disabled in Britain* to find only one reference to the general practitioner and that to say that everyone is entitled to a doctor's services—and that remark was in brackets. Yet it is part of my task almost every day to give advice to some patient in some way disabled about obtaining further help or as to whether such offers of aid as are made would be beneficial.

The family doctor must be aware of the special problems of disability in relation to employment. He is responsible for the demonstration and certification of disability and must often use these responsibilities to help his patient with the many socio-economic problems of disability in a welfare state.

The problems of old age and mental disability are very poorly catered for in our health service and the handling of, and possible resolution of these problems is part of the constant daily round of any general practitioner. He becomes, particularly for the elderly, a continuing and reliable presence in the community trained to give sympathetic consideration to the minutiae of existence that can help a person make the most of ability in the face of disability.

Psychological counselling for disability is a fancy name for a lot of common sense. Maybe in the rehabilitation unit it becomes a worthwhile exercise. Most of my patients do not need it and will not in any way benefit from it. My patients if given such counselling in the outpatient department merely seem to stay away from work rather longer than usual. What the majority of disabled persons and their families need is some rather simple on-going supportive psychotherapy. I often hear the criticism from within general practice and outside that the general practitioners' surgeries are filled with high proportions of 'psychoneurotic rubbish'. These patients undoubtedly occur but are in the minority. The majority are disabled, mentally or physically and need the doctor to give some simple on-going reassurance and this can make a material contribution to the continuing integrity of the family unit and its success in the face of many physical and social obstacles. The general practitioner accepts the responsibility for on-going care of the patient after discharge from the hospital or institution. He will proceed with therapy that may be advised by the specialist after the acute care is over and will become involved with many of the arrangements for living at home and attending work. In other words he is involved in the entirety of long-term management.

Finally, he has an important rôle in the preventive medicine of disability. It is a prominent feature of life (and not always an agreeable one) as a general practitioner in this country to make 'chronic' visits to the home-bound sick. This involves some social welfare visiting to the old and lonely; this involves the checking of a pulse and the supply of digitalis; this also involves the checking of joints and ranges of mobility in arthritis, the awareness of mobility and contractures in the hemiplegic, a co-operation with the district nurse and the health visitor in making life a little easier. In a routine way the general practitioner is daily using the simple techniques of physical medicine reinforced with drugs and psychotherapy.

That, as I see it, is the rôle of the average general practitioner in the rehabilitation of
the disabled: The total management of the majority of disabled people in this country in their home environment. Listed, it sounds dull and unexciting. There is little of rehabilitation, or of general practice that is dramatic but both are important, worthwhile and increasingly essential. Yet, while I believe that most practitioners are capable of doing these things, it must be admitted that some do not do them, or fail to do them well. In most regional hospital centres of this country, and indeed of North America and Europe, these things are not done well either. Sir Herbert Seddon tells me 'Facilities
for the disabled are deficient'. Why is this so? What is wrong? Where do we go from here and what rôle should general practice be playing?

Consider the system within which we work (figure 1). This diagrammatic representation of the system shows that we have in theory most of what we require and that the links are too few, and the services are enveloped in their own packages often well sealed. The practitioner for the most part still remains the patient's only immediate and constant source of help. While he is officially bolstered by the facilities of the medical officer of health and welfare departments the administrative iron curtain is often rather too solid for effective co-operation (figure 2).

In every package illustrated by these charts some sort of team approach to the patient is being achieved with a leader sorting out the results of the team investigation and giving the patient some advice or treatment as a result of their deliberations. It is fashionable to discuss the team approach to rehabilitation. In some centres of rehabilitation of the chronically disabled the team approach is even practised by orthopaedic surgeons who have admitted the necessity for full communication and involvement
at a professional level of all members of the team. The results obtained by this method at Rancho Los Amigos, for example, for me fully justify this philosophy.

In many rehabilitation set-ups the team led by the specialist in physical medicine has been considered as all that is necessary for adequate rehabilitation. Its importance is well recognized and almost always omits, or merely gives passing recognition to, the domiciliary end of the service where the majority of disability exists and is handled. I am told by specialists in institutional rehabilitation that domiciliary considerations are of importance and are achieved by reports from social workers or visiting therapists of one sort or another. The link with the general practitioner I am told by one of the leaders of the physical medicine profession is theoretically admirable but cannot be accomplished because the general practitioner has too little time, interest or ability for this work. This I cannot believe; for the majority of practitioners, I think, a better explanation would be that links with domiciliary practice are not achieved because the practitioner has too little incentive, opportunity or facilities.

The general practitioner is quite well placed to spend some part of his time in rehabilitation services and has the know-how and experience to make his involvement worthwhile. Many general practitioners apart from their routine National Health Service practice commitments are involved in remunerative part-time work. They supplement their incomes from jobs in industry, private practice, insurance practice, and as medical officers on various types of medical board such as those of the Ministry of Pensions and National Insurance and the Ministry of Labour. Other appointments are more directly concerned with the disabled. As part of the regulations for the setting up of the Medical Interviewing Committee of the Ministry of Labour it is required that a general practitioner shall sit with a consultant and advise the disablement resettlement officer. The award of war pensions often requires disability assessment by a panel of general practitioners. I mention these things to show that the general practitioner has time, interest and ability which may well be utilized by the specialist if adequate incentives were introduced to enable the practitioner to play a greater part in rehabilitation along with the hospital team.

However, it is infrequently recognized by our administrators and by the specialist that domiciliary management of disability as far as the specialist is concerned is a piece of paper with a fourpenny stamp arriving on the general practitioner's doorstep a week late. What's to be done? I suggest that we be more aware of two services that are already built into our system and use them more advantageous.

The system of domiciliary consultation brings joy to many a consultant and occasionally some help to a patient or a family doctor. Often it is abused, used to satisfy a disagreeable patient and bring an easy five guineas to the specialist. Often, the doctor and the specialist do not even meet and the system is rather a farce and the payment ridiculous. Nevertheless, used wisely it is a bridge, and could be a valuable bridge, across the services. Used as a deliberate policy tool it could give much aid to the disabled in his own environment and much encouragement and information to the general practitioner. As more ancillary staff, such as district nurses and health visitors get attached to general practice it seems not impossible that a rehabilitation team conference could take place in the patient's own home surrounded by his problems. There is no reason why, in selected cases, the consultant should not also take some members of his own rehabilitation team along. Though it might be considered touting for custom I should like to see the rehabilitationist suggesting such a follow-up domiciliary consultation in his discharge letter rather than merely making further follow-up outpatient appointments for the patient to be seen by a new member of the junior hospital staff each time he appears.

The other part of the system that is developing quite well in some parts of the country is the trend towards centralization of domiciliary medical services in health
centres. Using the financial resources of a large group of doctors backed by the administrative expertise of the public health department and well staffed with ancillaries a very much better and more scientific service for patients is going to be possible without recourse to the hospital. It is not unrealistic, I believe, to expect that under these conditions many family doctors will have more time to develop an interest in the growing number of disabled persons in the community and to provide care for them in such a health centre. A positive link between the specialized care of the hospital rehabilitationist and these groups of family doctors is going to provide a major breakthrough in bridging the gap in the services for the disabled. This gap in the professional services for the disabled is the thing that I feel to be my most difficult problem in the handling of disabled persons in the isolation of my practice. And the bridging of this gap is one of major importance.

Recently, Sir George Godber, discussing the professional isolation of the general practitioner, stated, "There has been a welcome sign of a partial reversal of this trend. The Platt report on hospital staffing foresaw increasing part-time employment of general practitioners in the medical assistant grade and a start has been made on this". I was happy to find on a tour of some of the major rehabilitation centres of this country earlier this year, that many centres were employing local general practitioners as clinical assistants and in all cases the directors of these institutes spoke highly of such an arrangement. I should like to see increasing use of family doctors in this way and I feel that rehabilitation services is one of those areas where the general practitioner's training and experience can be best used in the hospital service. The medical services for the disabled can be improved by a better use of medical manpower.

The general practitioner cannot remain an adequate doctor in isolation—he requires the educational and clinical environment of the hospital, association with specialists, with scientific medicine and research. On the other hand the family doctor can contribute uniquely to clinical teaching and research functions by bringing into the hospital his wide viewpoint and his unrivalled opportunity for studying patients in continuity among the varying social, economic emotional and organic factors in their make-up. The general practitioner has the time for some partial involvement outside his practice. It would be better to provide incentives for him to use this time in a clinical environment than in the bread-and-butter dreariness of the medical board.

Vocational resettlement is done well in this country, but it is slow. At all stages of the complex procedures for assessment, training, retraining and placement there are long delays and many failures. Here and there, Stanmore is a good example, the intimate involvement of a dedicated rehabilitation officer breaks through the red tape and the results become impressive. The general practitioner often is a person, maybe the only person, with a satisfactory knowledge of the patient, his background and his abilities. Probably also this general practitioner will know something of industry, industrialists and unions in his community.

It is not realistic to suggest that the general practitioner takes over the job of disablement resettlement officer but a close liaison with the general practitioner in the pre-discharge period may make contributions both to the patient's chance of early resettlement and to the doctor's interest in the case. The system, however, is structured against any such flexible approach even within a small community.

I believe that the sources of much dissatisfaction in the medical services of the country at the present time are to be found in conditions of service in general practice and the proper utilization of the hospital services will not come about till the problems at the point of referral, i.e. general practice, are solved. One of the problems of being a conscientious general practitioner is the feeling that so often one can do only half a job having no access to any beds and second-hand access to many other facilities. In relation to rehabilitation services for the disabled a Ministry of Health survey showed that some
27 per cent of all inpatients could be considered to be in a minimal nursing or self-care category. It would be reasonable to develop a system of progressive patient-care to relieve the acute beds of this high proportion and place them in a low cost self-care rehabilitation unit which should be attached to every general hospital. At this phase should be injected many of the rehabilitation, physical medicine and vocational guidance techniques necessary for more rapid return to normality.

Such units are suitable for the employment of the general practitioner clinical assistant and in many situations should take men from a general-practice training and background as director or co-ordinator of rehabilitation services. This sort of concept within the hospital, allied to the developing domiciliary health centre, will place the family doctor in a better position for him to discharge his responsibilities for many more of his patients.

It is up to all those sharing in the continuing care of the disabled to give these ideas a chance to mature by a development and a change in the attitude of traditional bigoted professional isolationism so that they may point a way to bridging the gap and bringing the hospital back into the community it serves.

The climate is now right for the implementation of some of these proposals. The financial obstacles should not be too great. There is a demand among management committees and regional board planning committees for an increased "throughput" in the acute wards of our hospitals and a reduction in waiting time. There is a push for increased quantitative care. As things are at the moment this can only be achieved by reducing qualitative care. It is reasonable to suggest that a system of progressive patient care cutting across the speciality barriers can be achieved by making provision for rehabilitation care after acute treatment is over and thus a guarantee can be given for increased quantity and quality of care.

Dr Glanville at Salisbury has shown that minimal-care rehabilitation-beds can function to the benefit of the whole district general hospital complex at 20 per cent of the cost of the acute beds. When this is linked to an increased "throughput" in the acute wards the rehabilitation system can pay for itself. Similarly the very sophisticated Toronto Workmen's Compensation Board Hospital has shown that with extraordinarily lavish appointments and facilities there is a 40–50 per cent reduction in patient costs per day. At this unit some $850,000 was spent on the rehabilitation of a group of 2,000 workmen who in the year after discharge from the hospital had a total earnings of $7.5m. These are the sort of investment and return figures that are necessary in our era of economic insolvency and these are the ways in which medicine has a rôle to play in contributing to a reduction in the costs of welfare benefits.

Maybe the hospital doctor and the general practitioner could become friends again and work for the benefit of the patient and the community. Maybe this field of locomotor disability is a good one in which to start, and then maybe we can be worthy of Voltaire's faith in us when he said, "Men who are occupied in the restoration of health to other men, by the joint exertion of skill and humanity are above all the great of the earth. They even partake of divinity, since to preserve and renew is almost as noble as to create." (Voltaire 1694–1778, A philosophical dictionary).

REFERENCES
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