

The prevention and management of disability in general practice*

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THE field of work of the general practitioner has been extensively surveyed over the past 20 years. Reports have appeared with increasing frequency from the early days of Collings (1950) through Taylor (1954) to Gillie (1963). Along the way, many detailed studies have defined the content of general practice, its organization and technique. The pioneer studies of Pickles (1945) were followed by the epidemiological data of Logan and Cushion (1958) and the practical study of Hodgkin (1963). They make a valuable contribution to the development of general practice as a personal service in a modern technological era. This development must take advantage of modern methods, both in organization and technique, so that team work can apply efficient diagnostic and therapeutic procedures.

These changes are beginning in screening clinics, in group practice and health centres and in the plans for new towns. Many will wonder how the personal link between practitioner and patient is maintained. This challenge to organization and communication needs further study and experiment. There will be many answers in town and country and in practices large and small, differing in history, personnel and circumstance. The purpose of this paper is to describe the role of the personal doctor in the prevention and management of disability and to suggest how it might be developed and improved as a key factor in the integrated health team.

Tradition and training ensure that the young doctor knows much about disease. The normal structure and function of the body and the changes wrought by disease are studied extensively. The patient's occupation, age, family and social history, symptoms and signs are recorded as pointers to disease. Laboratory and radiological investigations assist in confirming a diagnosis and, when available, the specific treatment is given. The hospital patient is then often allowed to return to his former way of life. Until recently, any attempt to evaluate the success of treatment has been confined to measures such as five-year survival rates. Reference is occasionally made to work records. Recently, the assessment of severity of asthma in relation to long-term corticosteroid treatment has been based mainly on the length of time lost from work (Maunsell *et al.* 1968).

The sociological implications of disease are at least as important as the disease itself. Morris (1964) has pointed out the rise in chronic disability in middle age particularly among men in their early sixties. This is partly due to medical success in death prevention and partly to difficulty in securing suitable employment for the disabled in modern industry. Ferguson and MacPhail (1954), in a study of 705 men discharged after treatment in acute medical wards of four hospitals in the West of Scotland, found that 25 per cent had died, been readmitted or clearly deteriorated within three months of leaving hospital. A fifth of 307 who had returned to work were in unsuitable jobs: the remainder, more than half, were not working after three months.

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Two years after discharge a third of the survivors had worked for less than one of the two years; many had done no work. A more recent study at other Scottish centres (McKenzie, *et al.* 1962) gave similar results and suggested the need for a more effective bridge between hospital and community.

The poor results of hospital treatment in chronic conditions contrast strongly with the success in treatment of acute conditions, such as pneumonia or appendicitis. In geriatrics and psychiatry it has been recognized that early treatment of acute incidents and the maximum support in the community give best results. The lack of application arises from lack of facilities. Similar policies have been adopted in paediatrics and chest diseases. General medicine and surgery lag behind in their appreciation of the community to which their patients belong. This is no criticism of individual kindness or competence, but suggests that the provision of technical facilities has outrun the assessment of their value to patient and community. Orthopaedics has a strong link with rehabilitation, but there is room for improvement. Fletcher and Wheble (1964) report an exercise in collaboration between a hospital and an industrial rehabilitation unit which reduced the average time interval from injury to admission for rehabilitation from 12 to six months. For specified injuries the average time intervals were as follows:

	<i>Special scheme</i>	<i>Other hospitals</i>
Fractured shaft of femur	33 weeks	70 weeks
Fractured tibia and fibula	28 "	49 "
Hand injuries	18 "	37 "

Specialists vary in their appreciation of the individual and community impact of disease. In cardiology, for example, there have been notable attempts to assess the effect of cardiac infarction on work (Sharland 1964, Caird 1967).

The general practitioner must pay an increasing part in the prevention and management of disability. General reference has been made to this role in the surveys of general practice mentioned at the outset. Little has been written about how this is done. The first essential is recognition of disability. This must then be investigated and assessed to determine how far remedial action is possible and how far there must be adaptation in personal attitude, in interpersonal relations or in the physical environment at home or at work. Even before this the general practitioner can recognize the possibility of disablement and by support and advice avert it.

"Youth is a blunder, Manhood a struggle, Old Age a regret" wrote Disraeli (1844). Let us see how we may avoid blunders, assist struggles and temper regrets.

Disease, disability and age

Disease is not necessarily accompanied by disability. Its effect will depend on the amount of interference with function and on the particular skills and personality involved. A left hemiplegia will disable both a violinist and a bricklayer. The loss of one finger of the left hand will disable the former and hardly affect the latter. It is therefore necessary to estimate the effect of disease on function and then to decide what this means by way of disability for the individual.

Youth, middle life and age have their different problems. Congenital defects are largely assessed between birth and first attending school. Where they are severe, special schools are available for the physically handicapped, the blind, the deaf, those with partial sight and hearing, the delicate, the emotionally disturbed and the educationally subnormal. The role of the general practitioner is to support the family in caring for the child, often by discouraging over-protection and by promoting independence. Sometimes parents sap the initiative of their children in their concern for their welfare. It is especially important to avoid this in the handicapped (Kershaw, 1966).

The child who leaves school with a handicap is often specially placed in employment. The majority will be able to follow correctly chosen normal employment. Some will find

normal employment but with special conditions of work. Others will need sheltered workshops. A few will be employable only at home or in an occupation centre. The approach to the handicapped child is fully and sympathetically described by Kershaw (1966). Until the age of 18 the youth employment officer gives guidance but the family doctor has an important part to play in taking over medical supervision from the school medical officer. No special arrangements exist to promote this. Unless there is a full industrial medical service medical supervision may lapse. Revised arrangements for the Appointed Factory Doctor have been suggested (Singleton 1966), but it is unlikely that these will be implemented in the near future. Serious consideration should be given to this work being undertaken by family doctors. Work in 'groups should allow one of the practice to take a special interest in the general supervision of health in places of work. This will require special training and adequate time. There will still be a need for more specialized knowledge about industrial health problems which the general practitioner may or may not have the opportunity to acquire. To expect the full-time specialist to be responsible for personal health supervision would further fragment the care of the patient. At the same time the number of factories and work places is so large that a smaller number of specialists could not achieve the personal contact with management and workers which is so important in continuing supervision of personal health: to attempt to do so would dissipate their special skill.

Apart from accidents, acquired disability is uncommon before the age of forty. There are exceptions, the commonest being neurological (disseminated sclerosis, epilepsy, myopathy), rheumatic (rheumatoid arthritis, valvular disease) and respiratory (asthma). The general practitioner has a special responsibility here to ensure that the benefits of assessment and placement in employment which the handicapped school child receives are made available to the adolescent and the younger employed adult. Because of their greater vitality and adaptability they may succeed without help. It is always desirable to avoid a change of occupation unless there is some positive reason for a change.

The likely course of the condition must be taken into account although some disabilities can invariably lead to restriction in employment; for example, driving or working at heights for the epileptic. Doctors should beware advising a change of occupation without clear reason and in the absence of a realistic alternative.

After the age of 40 it becomes more difficult even for the fully fit to change employment. Employers are reluctant to consider the older employee who is less flexible and requires more money for family commitments. On the other hand, stability and experience have their value and what is needed is to match capacity to job. When a change of employment is necessary and not readily available, a hospital or industrial rehabilitation course which includes assessment and reablement, but not new training, is indicated. Thereafter new employment with or without further training may be more easily found. This step should be taken early, before weeks or months of demoralizing unemployment have taken their toll. It will often be the duty of the general practitioner to suggest this. Some illustrative successes and snags are given later.

In the elderly the demands of unemployment become of less importance. Mobility and the needs of daily living, important in the younger, become paramount. The general practitioner has an opportunity, often not fully exploited, to look ahead for his patients and, by anticipating their needs, to prevent unnecessary deterioration. Much of this does not involve detailed medical examination but intelligent assessment of domestic difficulties. The role of a trained visitor as assessor of these factors will be discussed.

What is disability?

Dictionary definitions tend to be circular. "Disable v.t. 1. Incapacitate *from* doing, *for* work, etc.; cripple, deprive of power of activity. 2. Disqualify legally, pronounce incapable; hinder" (Oxford, 1962). Yet this definition helps us in establishing two

important aspects of disability. First, disability is linked to work and to specific functions. As such it is a negative concept: certain functions are impaired or absent. This should lead us to think of what is left, the usually far greater sum total of positive functions still available for useful activity. Second, there is the disqualifying effect of disability both in itself, hindering normal activity, and by legal or administrative decision. Some of these decisions are helpful such as disability pension and compensation; some are essential to protect society, the with-holding of driving licences from epileptics. Although not intentionally harmful unnecessary restrictions may be imposed by parents, employers or doctors. Some provisions have mixed benefit. The Disabled Persons (Employment) Act 1944 provides for registration of disabled persons. This may help them to find suitable work or may limit their choice and earning capacity.

The definition we have considered has a finality about it which is usually quite unrealistic in relation to disability. Some 'disabilities' become fixed and permanent at the moment they arise. An amputation will, objectively, have a fixed and unchanging effect. This concept is useful in assessing disability pensions. The report of the committee on the Assessment of Disablement (McCorquodale 1965) endorses the exclusion of the way in which the disablement affects the particular circumstances of the individual. Such an approach is most inappropriate in the care of the disabled person. Adaptation soon takes place even, perhaps especially, in the most stable and permanent disability. The result may be a fixed deformity with almost no loss of capacity.

There is a tendency for the functional concept of disability to be confused with a static concept of deformity. The latter is understandable in assessing pensions but unrealistic and harmful in the management of individual patients. After a time it may be best to accept a disability as static but not before all personal and other modifications have been made to reduce its effect to a minimum. In some conditions it will be best to reach this stable condition as soon as possible and not to delay return to full activity. In unstable or progressive conditions, such as asthma or multiple sclerosis, continuous adaptation is necessary. Only rarely will minimum functional disability require continued restriction of activity. After coronary thrombosis a period of rest and recuperation is required. This is often prolonged beyond what is essential. There is little objective evidence of the value of restrictions and no case for them when the infarction is healed and cardiac function normal. Considerable disability is still caused by restriction of activity when normal function is both possible and beneficial.

In considering the prevention and management of disability in general practice the concept of disability itself is not entirely helpful. It tends to be physical, extreme, and associated with deformity or severe disease. While this is helpful in keeping in mind what is to be avoided, prevention requires a sensitivity to developing functional impairment. The general practitioner must be aware of the school progress of the asthmatic child, at least in general terms. He must help the young adult with disseminated sclerosis to remain in full time work for as long as possible. Patients with rheumatoid arthritis need particular support in middle life both with work and activities of daily living. The elderly hemiplegic will require both personal and environmental help in adjusting to a full range of activity.

Human capacity for adaptation is so great that the concept of disability can only be a relative one. "There is nothing, either good or bad, but thinking makes it so" (Shakespeare 1623). Hamlet was determined to regard Denmark as a prison. Sometimes patients with relatively minor disabilities will make a prison of them by their attitude. Here the general practitioner with sympathy and insight will be able to do much to mould attitudes and promote adaptation. Preventive action is really threefold.

First, to encourage a healthy calm approach to ordinary problems and illnesses; inculcating a capacity for independence and eliminating a need for supportive therapy. Second, to support and advise when illness threatens to disable; to help the patient to

continue normal activities; and to provide a realistic estimate of necessary periods of incapacity. Third, to reduce the effect of disability when established and support the patient physically and psychologically in efforts to continue to maximum capability.

These three aspects of the general practitioner's role in prevention and management of disability are closely linked. They operate in practice by personal and interpersonal adaptation and by changes in the environment. Personal and environmental factors are influenced by method or organization in medicine and society. Personal, environmental and organizational factors will be discussed, with examples, in an attempt to reach some conclusions about the general practitioner's role.

Personal factors

A perpetual fascination of general practice is the reaction of one's patients to the events of life. The gradual acquisition of knowledge and ability in the child with a personality part pre-determined and part acquired; the reactions of the adolescent, the young married, the parent and the grandparent are the fabric of family practice. On this fabric the pattern of disease and death is closely interwoven with many more cheerful scenes. Holidays, weddings, birthdays and feasts appear on the tapestry as bright episodes in the workaday story. Often the general practitioner will be able to confirm Bacon's view that "prosperity does best discover vice, but adversity doth best discover virtue" (Bacon 1625).

Those doctors who regard more than half the work in general practice as trivial should remember that such consultations are an opportunity to get to know the patient and to try to direct the mind to healthy attitudes. The young person with frequent short absences from work may require more skilled help at this stage than when he was referred for tonsillectomy ten years earlier after repeated tonsillitis treated by oral penicillin. The young mother with recurrent diarrhoea will require understanding as well as adequate medication if she is to avoid disability and perhaps ulcerative colitis or even colostomy. The business executive or the heavy lorry driver afflicted in middle life by coronary thrombosis or hemiplegia will require encouragement and support to continue. The elderly diabetic or osteoarthritic will need similar help. The general practitioner's role in the established disability often seems moderately clear. Proper rapport between patient and doctor before disability occurs may allow advice to be accepted which will avoid or ameliorate disability when it appears.

A man of 36 had been employed for many years on his own account digging wells. He was overweight which increased his occupational hazard. He became frightened of being buried alive to the point of being inarticulate and weeping openly. Absences from work became more frequent and prolonged. Despite this he had fears about changing his job. He was referred to a medical rehabilitation centre where within six weeks his morale was restored and he was found a suitable job.

It is probable that earlier support and a reducing diet would have allowed him to continue longer at his chosen work and to make a change without distress, in his own time and without specialist help.

Personal adaptation comes by stages. Happy is the man who can be sufficiently flexible to allow for the unexpected in his scheme of things. The family doctor can encourage his patients to try to look ahead. This should not be by way of discouraging enterprise and boldness. It should foster an optimism tempered by reality. Doctors constantly need to beware of believing in the infallibility with which some of their patients would like to invest them. It does not necessarily follow that the family doctor's opinion is correct or that disaster will follow its being ignored.

A housewife with working, single daughters, one of whom was an epileptic and the other repeatedly late for successive jobs, asked for treatment for her recurrent dyspepsia and insomnia. She asked for a change of hypnotic and then, given an opening, spoke of her worries over her daughters. The epileptic girl, aged 21, had had two major fits in the past year, one resulting in injury. Her engagement had recently been broken off and she announced her intention of marriage within three months of first

meeting to the 18-year-old son of a disabled and unemployed miner whose family 200 miles away to the north she had not met. Rather surprisingly she brought her fiancé, about five inches shorter than herself, along and listened patiently to a homily about hasty marriage. This did not alter their determination to marry forthwith, but at least the couple had some practical information about epilepsy and contraception. Up to this point they had no home but, as advised, soon found lodgings in the town. No doubt they will need further help but the chain of communication has not been broken and some of the more obvious pitfalls have been avoided.

Whether this is as important as the diagnosis of acute appendicitis or Fanconi's syndrome is hardly relevant. It needs to be done and it is very interesting. Curing is important but so is caring. This is not the sort of work that is appropriate to refer to a medical social worker because of the medical issues involved. The sister with her employment trouble might well be so helped but at present she has decided to be a steady worker.

Disability often requires personal adaptation not only by the patient, but by family, friends, workmates or employer. The extent to which this can take place is determined in part by the previous relationship. A warm and understanding atmosphere will be helpful providing there is not an excess of sympathy.

A man of 57 with mitral stenosis and auricular fibrillation sustained a sudden left hemiplegia. After a few weeks in hospital and a course of physiotherapy he was able to get about but with a residual hemiplegia. He handed his tobacconist and newsagent business over to his son, maintaining that he would no longer be able to manage the figure work and became very dependent on his wife whom he would not let out of his sight. They both enjoyed bowls and he was encouraged to attend matches, and to bowl again himself. His wife became acutely depressed at her husband's dependance and required antidepressant drugs. She improved and this was maintained when her husband reluctantly consented, after some pressure from the county occupational therapist, to attend for weekly occupational therapy. The value of this type of activity in association with general practice requires further evaluation beyond the scope of this paper.

Another facet of the family doctor's role in helping personal adaptation is seen when his patient is referred or admitted to hospital. Whenever possible the patient should be told why the reference is being made and what it is hoped to achieve. It is preferable to express this in terms of functional disorder rather than disease processes. "Your indigestion is giving you so much pain and vomiting that your work is suffering. I have had you x-rayed and I am going to ask a surgeon to see if he can help". This does not exclude discussion of peptic ulceration or pyloric stenosis if this is what the patient wants, but it shows him that it is the functional disability which is as important to the doctor as to the patient. Similarly, this information will be of great importance to the surgeon in deciding whether to operate.

When the patient is in hospital a visit from 'his own' family doctor will reassure and help to answer any problems. Liaison with hospital staff may allow a programme of convalescence to be mapped out, with return to work as a goal, within a day or two of operation. This is perhaps even more important with sudden illness or accident. The family doctor by his presence shows his association with the hospital team. While it does not obviate the need for a prompt written report, the patient feels that he is being handed back to his doctor who is completely in the picture. This is especially important in coronary thrombosis and will be more so as more intensive care units are established. The patient will require great reassurance that he can survive without the formidable array of instruments with which he was so recently surrounded. He must be convinced that the programme of progressive activity that is mapped out for him is approved by the specialist physician.

Occasionally it may be necessary to intervene on behalf of the patient with others in his life. The hemiplegic's wife was helped by discussing her husband's dependency. In dealing with close relatives it is not always advisable for the patient to know what has been said or even that a discussion has taken place. If improvements can be brought about in interpersonal relationships it is much better if they arise between the persons

concerned and not at the behest of a third party. In dealing with employers it is essential to have the consent of the patient. This also applies to confidential communications to industrial medical officers although it is to be hoped that a statement that the employee's consent has been obtained can be accepted; it is wise to remember that it is difficult for an employee to withhold consent from his employer. A personal contact with the employer will allow confidences to be respected and used for the patient's good. There are times when it is unrealistic to hold out hope of a return to former work. Some firms have enlightened policies in re-employing disabled workers. Some even run rehabilitation departments, for example Vauxhall Motors at Luton and Pilkington's at St Helens. Interpersonal relations at work may be responsible for stress and the employer is sometimes able to revise the span of control or make a helpful change in sphere of work.

Personal factors considerably influence a patient's adjustment to disability and the conflicting advice from family, friends and fellow workers can produce much anguish. Firm and informed guidance or reassurance is one of the greatest weapons of the experienced general practitioner. Unfortunately, the patient's fears and worries are often ill-expressed and need experience to elicit, understand and dispel.

Environmental factors

Personal factors are important but it is of little use to think of disability in isolation. Functional assessment will show both abilities and disabilities, but these must be related to the individual and to his background at home and at work.

Two brothers with osteogenesis imperfecta have suffered multiple fractures. Both are now wheel-chair borne. The one, aged 21, is studying accountancy at a local technical high school. The other is at a school for handicapped children. Both are highly mobile, can swim and are encouraged to do so with supervision. The younger boy had a recent fracture. This allowed a deformed leg to be straightened so that a spill from the wheel chair was turned to an advantage as well as a warning for the future. They are in the process of choosing their environment so that they can live life to the full within their limitations.

A man of 70 has osteoarthritis of the hip, superimposed on polio from childhood. Until this supervened he led an active life as a coal porter. Now with a walking aid and a wheel chair and with half steps at the doors of his ground-floor flat, he is still moderately active. When last seen he was sawing logs for firewood with great vigour. His wife has had her complete proctentia repaired in time to attend St John first aid lectures in her seventy-first year.

There is a great deficiency of suitable housing for the elderly and disabled. Adequate provision could make a great contribution to the prevention and management of disability. How many hospital beds are occupied by elderly ladies who have fallen down a flight of stairs to fracture their hip? Proper housing would prevent much of this. Any experienced practitioner soon tires of writing notes to the housing authority.

In one small town with good welfare provision, an elderly lady, recently widowed and hypertensive, lives alone in a house far too big and inconvenient for her advancing years. This accommodation could house a family but there is no prospect with the present waiting list of 80 persons of her being accommodated in a bungalow or welfare home or flat for at least five years. This is in a good area with a population of only 20,000. The deficiency in the country as a whole must be enormous.

If the general practitioner cannot prescribe a new home he can see that the best is made of the existing home. Adequate lighting on stairs and a strong handrail could prevent many accidents. This is not a place to discuss the numerous aids to daily living which are available. It is proper for the skilled helper whether medical social worker, occupational or physiotherapist to make this provision. The doctor's role is to see that it is considered and to encourage the patient's activity.

Similarly, at work it is often possible to modify the job or the environment so that the disabled worker can continue. If there is an industrial medical officer this must be left in his hands although the general practitioner must know the facts on which a decision is based. If there is no firm doctor the personnel officer or employer may hesitate

to approach the general practitioner. Let it be said that the unhelpful way such approaches have been received by some doctors makes the employer hesitant. At present it must be exceptional for a general practitioner to go to see his patient at work. There is far more reason to do this than to make some of the home visits for infectious disease or feeding problems which have been usual. These are properly left to the health visitor to make time for work which only a doctor can do.

Thus the role of the general practitioner varies from relatively simple modification of the home environment, such as a handrail, a half-step or a high stool, through walking, dressing or bathing activities, to housing modification and provision. At work the factors may be simple, such as working height or avoiding a sensitizing agent, or they may demand full investigation in conjunction with personal assessment by an occupational therapist or at a special rehabilitation unit. It is for the general practitioner to decide what is required. He may not always recognize this.

Organizational factors

Any co-ordinated human activity must have an organizational scheme. In the past general practice has not been very organized. Appointments systems have contributed enormously to a rational plan. Patients have time to arrange their thoughts and at the end of the first consultation it is possible to plan ahead. This is not the place to discuss reasons for patients consulting their doctor. What is important is that physical symptoms should not necessarily be taken at their face value. Why is this pain or that cough brought to the doctor? In every session there will be consultations in which the patient is seeking advice or support and not merely relief of physical symptoms. If the general practitioner is sensitive to this, disability may be avoided. To find time he must be organized.

A married woman complained of headache and insomnia. She had a daughter aged four and had recently moved to the district. She works in her former district in a job that she had held for seven years as a secretary to a technical expert in a large organization. Her boss had been away and much of the work of quality control had fallen to her. She was clearly highly competent and her boss was alarmed to find on his return that she had applied for another job. Two weeks off work and further discussion, with some sedation, was followed by a great improvement. She was torn between loyalties to her home, her child, her husband and her work. With help she resolved the conflict quickly. It seems likely that drugs alone would not have procured an improvement so quickly and that she would have left work or taken a less suitable job. Money was short and she had to work. She has continued to do this without disability.

The above example is a fairly simple and everyday instance of the general practitioner's role in the prevention and management of disability. It is difficult to keep account of a patient's time off work and the recording of dates on and off work has practical importance. Similarly when a patient is referred to hospital the family doctor may lose touch. There may be some advantage in keeping a continuous progress chart of those off work and attending hospital so that the situation can be reviewed from time to time. Patients can get 'lost' in hospital so that the general practitioner loses contact and is denied an opportunity to help.

A man aged 43 developed ill-defined muscular pain in the neck which followed minor injury at work. He was referred to an orthopaedic surgeon, and by him to the physical medicine department. After two months the general practitioner was unable to tell the doctor at work the patient's condition and agreed to his being seen by the latter. A modification of his usual job was available the following week, and he returned to it. He was back at full work within a month, being seen and encouraged at work on three occasions. The general practitioner played his part by co-operating with the doctor at work. Had he known more about the circumstances he might have taken the initiative in reducing disability.

It is rare for a general practitioner to approach firms asking for modification of work. Notes asking for light work are almost useless. Occasionally the patient can arrange something suitable. A note offering to discuss suitable work with the employer would be of more value, or a telephone call or a visit by a medical social worker or occupational therapist in consultation with the general practitioner.

Patients may be admitted direct to hospital and then often no notification is sent to the general practitioner. If he is notified he may not think any action is required by him; such cases are accidents or sudden illness, especially coronary thrombosis and hemiplegia. These patients need much support and carefully planned rehabilitation from the day of admission. There is a role for the general practitioner in supporting morale and interpreting the medical details to the patient. He will learn a lot by going to the hospital and he may contribute much to the patient's care. It should not be necessary for him to take the initiative in planning rehabilitation although occasionally this may need a stimulus. As recovery progresses he can contribute to deciding a planned course of action. Many hospitals do not have any set conference at which the resettlement of difficult cases is planned. This was a recommendation of the Committee on the Rehabilitation, Training and Resettlement of Disabled Persons (Piercy 1956), but it has not been widely implemented.

Disease orientation may result in obvious functional requirements being overlooked.

A 58-year-old wood-turner was admitted for operation for acute glaucoma and discharged after 18 days. He was told on discharge that his glasses might need changing but at follow-up nothing was done about this. Three weeks after discharge he was advised by his general practitioner to try out his glasses at a visit to his place of work. They were not satisfactory and it was arranged that he be seen again four weeks after discharge. He was then referred for refraction, involving a wait for a further appointment and he was eventually able to return to work three months after discharge. Two months of this was waiting for spectacles. This is an extreme example but it illustrates that the specialist can overlook the functional objective and the general practitioner has a role to play in allowing reality to break in.

The medical social worker has an undoubted part to play in helping those who are already disabled. However, if consulted early with full details of the likely course, treatment and progress, more help is available to the patient at home, at work or by suitable resettlement. Unfortunately this advice is often unsought, or insufficient regard is paid to recommendations. Much welfare work is carried out by local authority workers, both in general welfare and advice. They arrange social activities, holidays, structural alterations to the home, motor-chair garages and aids (Pringle 1968).

However, too often the general practitioner is not consulted about these activities and thus a central focal factor is missed. The general practitioner has an important role to play and must be at least informed about these activities. It is by retaining this focal interest that the necessary co-ordination of clinical, welfare and social aspects can be obtained.

The various facets of the prevention and management of disability in general practice come together in the following case.

A man now aged 63 has a colostomy. He left the R.A.F. in 1945 to drive a London Transport 'bus. In 1949 he had renal colic and in 1951 coronary thrombosis. There followed five anxious years with attacks of colic and several months of tinnitus and vertigo until he passed a stone at the end of 1954. No longer allowed to drive a 'bus for reasons of public safety he gradually resigned himself to life as a conductor. In 1957, when he had backache, an orthopaedic surgeon thought he was "rapidly ageing" and unable to cope. In 1961, after four months of bowel symptoms, a pelvi-rectal carcinoma was removed. Within six months, with the blessing of London Transport's medical department, he was back conducting single-deck country buses. Despite developing recurrent winter bronchitis he has continued to work satisfactorily for seven years with a colostomy that is not always docile. Any one of his many conditions could have left him unemployed with less enlightened employers. He is of a temperament which would have taken unemployment badly.

How many unnecessary casualties are there in industry? The general practitioner must always support his patient. To give realistic advice to the employer in harmony with necessary restriction is good prevention and management of disability.

Conclusions

Little has been written on the role of the general practitioner in the prevention and management of disability. This is not because nothing is done; general practitioners

are immersed in it, and experience teaches ways and means. Explicit study and reporting might improve personal care and co-ordination. The following points are put forward for consideration:

1. Emphasis on the diagnosis of disease must not obscure its effect on function.
2. Any assessment of function must include positive abilities, work experience and potential. There is scope for study of methods of assessment and means of communication of results.
3. The role of the occupational therapist in making these assessments and in advising about aids and work needs study. It is a waste of her training to use it mainly in organizing diversional activities.
4. The sociological impact of disease and disability must be taken into account. There is 'need for a more effective bridge between hospital and community'.
5. Discovery of disease and some specialist advice may aggravate minor disability. Care in the community is best.
6. Rehabilitation must start early. It is sometimes delayed and the general practitioner can help to avoid this.
7. Disability is difficult to define and the concept has disadvantages. The general practitioner should emphasize abilities and help the patient to adapt at various stages of life. Over-solicitude must be avoided.
8. The degree of disability is greatly dependent on attitudes. The general practitioner can prevent or minimize disability by encouraging healthy attitudes. The timing of help is important, especially in planning ahead.
9. Patients require the support of their general practitioner when in hospital, to interpret to them what is happening and to the specialist what this means to the patient in his home environment.
10. Resettlement conferences, to decide how to help the difficult case, should include the general practitioner.
11. Contacts with the industrial medical officer or the employer are to be encouraged. General practitioners should visit more often at work and less often at home for common self-limiting ailments.
12. Suitable housing for the disabled and elderly is grossly deficient. Housing improvements would do more for health than technical triumphs of laboratory medicine.
13. Aids to daily living and modification of home or work environment may be arranged by the general practitioner.
14. Organization and co-operation are required. A continuous progress chart of those off work or at hospital is suggested. Medical social workers help in preventing and relieving disability.
15. Activity prevents disability and work restores ability.

The general practitioner is not only a doctor of diseases; he helps his patients to adjust to life and circumstances, to avoid disabilities and if they cannot be avoided to deal with them. It is an exacting role requiring scientific knowledge, organization, patience and co-operation. Further study will allow better prevention and management of disability.

"Man was made for Joy and Woe
And when this we rightly know,
Thro' the World we safely go,
Joy and Woe are woven fine,
A clothing for the soul divine."

(Blake 1803)

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Development of the nursing section of the community health team. JOHN C. HASLER, M.B., M.R.C.G.P., D.A., D.C.H. et al. *Brit. med. J.* 1968. 3, 734.

The 'integrated' practice described in this paper serves a population of 6,800 (semi-urban and rural) and consists of three general practitioners, three administrative staff, one district nursing sister, one health visitor, two treatment room sisters and one district nursing auxiliary. The district nursing sister, health visitor and nursing auxiliary are attached local authority staff.

In addition to routine district nursing visits the nursing sister undertakes diagnostic and therapeutic visits for the practice, recording the results of these in the patients' N.H.S. records. The treatment-room sisters in addition to dressings and injections, take blood samples, ECGs and Wright peak-flow meter readings.

The advantages of this type of integration are enumerated and also the necessary safeguards required for the smooth working of the system.

"We sincerely believe that teamwork of the kind we have described is the main factor that will enable the standard of general practice to improve in the face of an increasing workload, and allow the community health service to play its full part in medical care in the future."

Dispensary medical service 1967—an analysis of one year's work in Athy (West) dispensary.

BRIAN MAGUIRE, L.R.C.P. & S.I. *J. Irish. med. Ass.* 1968. 61, No. 371, 162.

In one year, with a medical list of approximately 2,400 patients, Dr Maguire did 562 domiciliary visits. The monthly figures varied from 29 in March to 100 in December 1967 (when there was an influenza epidemic). In the month of January 462 prescriptions were issued at the nine dispensary sessions held in that month. No sleeping tablets were prescribed during this period. During the year 310 patients were referred for consultant opinion.

[The writer does not comment on the fact that his home visiting rate is considerably below that usual in this country. The Irish dispensary service provides medical services to lower income groups only, and it is quite usual for a registered dispensary patient to consult a private doctor and pay his fee while remaining on the dispensary doctor's list.]