Our own efforts as general practitioners in association with hospital specialists constitute the main rehabilitation services in my area. The work of the Disablement Resettlement Officer can often be very rewarding, but suffers from the same limitations due to the same factors that I have previously described. Local authority welfare departments do useful work in connection with rehabilitation, but without reference to the general practitioner, and, through lack of medical guidance this often results in unsatisfactory domestic aids and structural alterations for the benefit of the disabled.

Problems of rehabilitation and resettlement vary widely over the country. I have tried to outline the particular ones which affect my area, while realizing that they are not representative of all mining areas. You may not agree with some of my suggestions, but if they stimulate you to produce better ones for the ultimate improvement of the rehabilitation services, my purpose will be amply fulfilled.

## DISCUSSION

**Dr C. C. Lutton** (*South-east Scotland Faculty*): I work in a large practice with four doctors and we have many miners in our practice. These miners get to know their doctor very well because they are often ill and often hurt, and because familiarity breeds contempt they get to know our weaknesses. They also realize that they do not know the R.M.O., so that when an R.M.O. calls up a miner the chances are that he will come back wanting to return to work, whereas in fact you have often tried to get him back to work over the preceding weeks, and now a note from the R.M.O. automatically makes him want to go back. Possibly if we referred more of our patients to the R.M.O. some of them would go back to work sooner, because when you get to know a miner and his family well, and you know that at heart he is quite a good, decent chap, and he is getting older and his breath is not so good, and he has had a good deal of injury in the past—it is very hard to be hard on him. Sometimes you try and persuade him to go back to work when you know yourself that you would not like to go down and do his job. Then when miners go to hospital departments one can sometimes tell from the tone of the consultant's letter that he has never been down a coal mine, and sometimes you get a consultant, in his ignorance of the working conditions, making suggestions about a miner going back to work, when if the consultant—perhaps even as a medical student—had been taken down a coal mine or into a

steel factory he would have acted differently. Possibly if we knew more about working conditions in the country we would be able to handle many of the problems better. As a medical student I was never taken down a coal mine or round a factory, and I think I might well have learned more by doing this than by attending botany classes at half past eight in the morning. Many of the older miners tend to be a passenger when they are at work and obviously they do not do a fair day's work because they either haven't the morale or the physical capacity to do it. On the other hand, there are many young men in Britain doing work which they should not be doing. The only way I can see to end the problem is to educate consultants and doctors in the real working conditions of the various industries, and for the Minister of Employment to make it easier for a person to transfer from one industry to another. I recently had a young miner of 33 with rheumatism, so I advised him to leave the mines. He went to Birmingham and got a job in the car industry which he could easily do, but the unions would not allow him to start, so he came back to our district and he is now down a coal mine again.

**Mr Paterson:** I agree that every consultant has not been down a coal mine or gone round an engineering workshop, but this is where we depend on the practitioner. This in fact is what the practitioner is there for—he knows the man and his work and his surroundings, and this is exactly the part the general practitioner wants to play. The consultant can only advise the practitioner on the standard and type of work to be done and on the man's disability. It is then the practitioner's job to do his best for the man. This is the practitioner's province and it would be wrong for the consultant to try and take it over.

**Dr C. P. McGowan** (*Glasgow*): It may be of interest to tell you about the service we have in Lanarkshire. I work in an area which is not now a mining area but at one time was extensively so. And an organization has been set up in Lanarkshire. There is a miner's rehabilitation centre at Uddingston, and the great advantages of this are that immediately a miner is ambulant he can attend that centre, go there all day, have his meals there. At the centre he is dealt with by people who deal impartially, whereas the practitioner is very much on the ' old boy ' level—as has been pointed out, his weaknesses have already been observed by this miner. When the man has finished his course of rehabilitation he is regarded as fit for work by people with whom the miner feels he cannot very well argue. And when he is referred back to his practitioner the task of getting him back to work is very much easier. This is the kind of organization that I feel may help in such circumstances.