Discussion

Dr H. Sutherland (*London*): I was interested in what the last speaker said about the various points of contact between rehabilitation and the return to work. As a part-time referee working for the Ministry of Health, I find there is a tremendous time lag between rehabilitation of patients and their actual return to work. Again and again a person who has some disability, even a fairly minor one, is put off, and sometimes it is years before a result is achieved. There seems to be a bottle-neck so often between the DRO and the various jobs. What can be done to save the productive time of men, particularly between 40 and 50 years old, who are often put off for many years with some minor disability?

Mr Daniel: This is the problem that confronted the Royal National Orthopaedic Hospital when they appointed me, I suppose. They found there was a time lag. At that time they were dealing with poliomyelitis and their people were staying off for too long, but we found that by producing contact between the firm and the patient we could overcome the problem much more easily. For the past two years I have been engaged in research in one particular disability and looking at the problems of resettlement. This is the brachial plexus lesion, and I am finding people who have been off for three years or more for no reason whatsoever. Fortunately, we have an upper limb clinic to which they are now referred, I contact the hospital concerned and a number of people have been resettled in this way. The major problem is lack of pressure, if a patient wishes to sit back and let things take their course, it is not very difficult for him to do so.

Dr J. McMullan (*Chesham, Bucks*): I would like to suggest one possible answer to this question, I think quite often patients 'get lost' between the general practitioners and the hospital. I spent some time in occupational health with a large national organization and we were often in correspondence with doctors who wrote rather guardedly in reply. When one rang the doctor up, one heard a very different story. They were not quite certain what had happened, whether the department of physical medicine had got the patient, whether the orthopaedic surgeon had got the patient, or whether even the psychiatrist had got the patient. I am sure it happens that the patient, so to speak, gets lost. I have got an example in my own practice now, a patient with rheumatoid arthritis of acute onset who went into the local hospital and was then referred to another unit. She went into hospital a year ago, and after three months I began to think that it was time for her to be going back to work. But two weeks later I got a letter from the research assistant to say, "Perhaps the patient could have the blood test at your local hospital now; it would be much easier and she would not lose so much time from work."

Miss K. Macindoe: I think a lot of patients do not understand how the DRO works. Mr Daniel is lucky, he is there to do quite a lot of the work himself. Hospitals very often tell the patient that the DRO will get in touch with them, but this is not the case; the patient has to want to get a job and he has got to keep nagging the DRO.

Dr Ansell: Park Rehabilitation Centre, which is just near us at Taplow, sends a DRO to us and one of our male occupational therapists goes round to the factories concerned; we get the patients back to work much more quickly from there than we do if we refer them through the ordinary channels. Once you have this personal contact you can get a patient who wishes to work, back fairly easily, but that is not so if they come to an ordinary outpatient department. I must stress the point, 'wishes to work'. There is one notable patient going around between five of us at the moment, who always asks to see the registrar in one particular department and always says how much worse he is and how he cannot possibly work. He knows that we all consider he is quite fit to go back to work, but invariably a letter goes back to his doctor, who knows our feelings on the matter, from the registrar saying he is not fit to work. It is very difficult sometimes.

Dr B. Zoob (*London*): As regards this problem of getting patients moving and resting, I often feel a bit lost myself because I never really know in my own mind just when the rest stops and the work should start. I cannot help wondering sometimes whether that is not communicated to the patient; maybe those first words that we say to them in telling them to rest the joint causes a block after that. They somehow never seem to get past that block and feel that

if they go to work their joints are going to be worse and then when they are ten years older they will not be able to move at all.

Chairman: I would like to ask Mr Daniel what his relations are with the local DRO's?

Mr Daniel: We call them in. The trouble is that unless the Ministry of Labour really get down to the fundamentals of making the DRO service a career structure within the Civil Service, there will not be good rapport between hospitals, general practitioners and DRO's. There is no continuity in this service and I think this is tragic. They have got an awful job because they have to build up their contacts and by the time they have built them up they very likely have to lose them again.

Dr L. Oakshott (*Thorne, Yorks*): It seems to me there are two factors involved with getting people back to work again. Am I right in saying that if a man has been off because of an accident a firm is quite pleased to take him back as quickly as possible because it obviates a matter of compensation, whereas if he is off through sickness the firm are not quite so interested?

Mr Daniel: Basically you are right. We deal with all types of cases but in hospital it is nearly all works accidents. I have to be guarded in dealing with the firms who say they will take the employee back, and the man who says he will not go back because he has been told he will get more compensation if he does not. I have got to mediate between the two. However, if you do build up a relationship with firms they will not try this, and the same applies to the trades unions. I have been doing this job now for nearly 20 years so they know who they are dealing with; they will try it but not with me.

Dr Windsley: May I ask Miss Macindoe about holiday facilities for disabled patients. I have quite a few who have suffered from rheumatic conditions and I always have great difficulty in getting them temporarily placed in a hospital or holiday home to give some sort of relief to the relations who are looking after them. I wonder whether you have any information regarding this particular problem, which I think is an important one.

Miss Macindoe: Some of the boroughs are rather good at arranging things like that and there are a few homes that will take chairbound people and those who need help. There are disabled persons' holidays with lots of volunteers to help; there is one particular home at Lulworth Cove which will take any type of disabled person except a chairbound person with straight legs because the lift is too small. But you have to book about January. I think it is difficult to get patients taken into hospital for a short stay, but I think that comes into the field of geriatric care. It all depends upon individuals and local circumstances.

Dr G. Gomez (*Wimbledon*): I would like to ask what we can do to give our patients occupational therapy in the home. Is it still rug-making and leatherwork or are there some new ideas? I would also like to ask Miss Macindoe whether she could tell us something about sheltered workshops, in particular the Woodlarks and Lighthouse schemes, and what other sheltered workshops are available and which patients would benefit from them.

Miss Painter: There are day centres where occupation is the main form of activity, but I think you will find that in most hospitals now they are so taken up with enabling people to be made independent in some way or another and retraining for their jobs and getting them fit for Mr Daniel to place back in industry, that there is not much time in the occupational therapy department in hospitals to provide maintenance occupation.

Dr Ansell: The British Rheumatism Association runs one hotel at Birchington for arthritic patients, which charges for admission but it is not terribly expensive. They also have a number of other guest houses, homes and hotels a list of which can be obtained by writing to the British Rheumatism Association.

Dr Lask (*London*): Could you indicate the criteria governing the provision of mechanical aids for rheumatoid arthritis?

Mr Daniel: There are three main points. The first is that the patient has to be a paraplegic or a bilateral amputee or have a disability that would debar him from getting to work by public transport; secondly, he has to have a job; thirdly, if he cannot get to work by public transport, he will qualify for a vehicle.

Dr Ansell: But it is the doctor at the appliance centre who actually decides.

Mr Daniel: The form is sent in and then the Ministry of Health doctor will assess medically. The Ministry of Health technical officers assess technically and then if their assessments agree

the findings are sent to Blackpool where a committee meets once every two months to decide who is eligible and who is not. If the patient has nowhere to garage his vehicle the local authority has to provide a site; when they have done this the case goes back to the Ministry of Health who will then permit them to put up a garage. All this takes quite a time.

Dr Ansell: There is also one other thing that you can do if a person is too disabled to drive one of the vehicles they provide and has a job. The Ministry of Labour will provide a taxi service; I have several cases of Still's disease who are unable to drive a motorized vehicle but who are going to work daily with a taxi service provided by the Ministry of Labour, for which they pay a part but not all.

Dr Lask (*Ealing*): Are vehicles provided for people who are not working?

Dr Ansell: No. They have been allowed them on occasions such as when there is a young mother with a family to rear, but it has to be possible for them to be employed.

Miss Macindoe: You can get them for housewives without a young family; one was recently provided for a middle-aged woman.

Dr Ansell: I had a patient turned down at Reading. She has gone back to live elsewhere near Cambridge and has been accepted for one there. There are many difficulties over this.

Dr Lask: May I ask Dr Ansell about the incidence of other illness in chronic patients. Is it a rarity? Do arthritics have other illnesses before they develop arthritis?

Dr Ansell: This is difficult to answer. First of all, rheumatoid arthritis has a wide spectrum of disease and I have dealt in the broadest outline with it from children up to grandmothers. Everyone by the time they get to 70 has had a number of illnesses. Among our own juveniles which we follow very closely at Taplow there does not seem to be much extra disease; the incidence is usually about one in 500 and there seems to be no particular risk for the younger people with rheumatoid arthritis; older patients get more or less the same sort of diseases as anybody else.

Professor Bywaters: In general this is true but then they tend to live rather sheltered lives, they are perhaps not as subject as most people are to trauma, but they do have the same kind of diseases as other people. I do not think they are particularly prone to illness apart from gastric disease.

Chairman: This applies to so much of our work, with psychosomatic disease especially. The fact that one is nervous does not make one immortal.

Summing up

Professor Bywaters: I am not sure that summing up is really a useful exercise; certainly it is a difficult one. Everyone carries away from a symposium like this a different impression, depending upon their own particular approach, so I will not attempt a summary of what people have said today but will only give briefly my own personal impressions.

The most important and I think the most perceptive remark we had today was to my mind Miss Macindoe's, 'What sustains the arthritic patient is the feeling that his doctor was interested in him and wanted to see him'. Someone has said that the secret of patient care is in caring for the patient whether we are almoners, physiotherapists, occupational therapists, consultants, family doctors or even residents; it is really hardest for the residents because they are there in a transient capacity. Hope on the positive side and freedom from fear on the negative side are the most important of all ingredients in medical treatment and medical care, as the speakers have emphasized. If the people