document, *Patients First* (DHSS, 1979), followed up by proposing the removal of the area tier and the establishment of district health authorities. These were usually to be based on existing districts and within them the 'unit' level was to be strengthened and functional management reduced. These proposals have now become decisions (DHSS, 1980), with a timetable for the new district health authorities to be established by April 1982 in most cases. There is great emphasis on delegating both strategic (10 years on) and operational planning to the new districts, and on reducing the role of the regions, but whether this will actually occur is doubtful. There is no doubt, however, that the new authorities will have great freedom in deciding the best management framework within their own district.

Although this greater simplicity is to be welcomed, the influence of primary care could well be reduced. The emphasis on integration, which was a feature of the 1974 changes, has faded away and much will depend on decisions taken by the new authorities over the next year or two. They will be established in 'shadow' form in the late summer. There are two issues which may create problems. Firstly, a revised medical advisory machinery within districts has been proposed by a working party of the Chief Medical Officer (DHSS, 1981) which, amongst other proposals, would eliminate the district medical committee and replace it by a system of cross-representation. Its recommendations will inevitably lead to a weakening of the role of general practitioners in the advisory system and in some places the task for the general practitioner member of the new district management team might become impossible. These proposals have already attracted criticism; they are not obligatory, and general practitioners would do well to ensure that such a system is not adopted in their own district.

Secondly, the new 'units' are likely to be interpreted by many districts as hospital units rather than the integration of health services within a geographical vicinity. The risk of general practice being excluded from local planning and decision-making is obvious, and there is danger of a return to the tripartite philosophy of pre-1974 unless we insist on involvement at unit management level and on all unit proposals of a medical content being channelled through district medical committees. The present obligation on health authorities to consult such advisory committees should be retained.

Amidst all this change, the Family Practitioner Committees in England and Wales are to remain as they are, and the DHSS has proposed that they become more involved in planning. Since most will have two or more districts within their area, it is hard to see such arrangements being successful. FPCs seem destined to become increasingly isolated unless they are re-established at district level. A more controversial prediction might be that, if general practitioners can develop confidence in their role within the new district health authorities and be assured about their own contractual status, FPC functions may eventually be taken over by the district authorities.

Summary and conclusions

There is now an opportunity to establish the fine ideals leading to the 1974 reorganization within a simpler and more workable framework. Many decisions in this process will be made at district level, and the way is open for general practitioners to become fully involved in planning their local health service, provided they have the will to assert themselves.

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The rehabilitation of stroke patients

COMPLETED stroke is the commonest cause of severe permanent physical disability in Britain, and the care of stroke patients consumes a considerable proportion of acute medical resources. The numbers of patients to be considered and planned for are based on an incidence of 150 per 100,000 per year, and a three-week survival ratio of 60 per cent (Langton-Hewer, 1976). For a doctor with an average list, this means about six new cases of stroke per year, with four survivors, three of whom will be left with considerable disability, usually a hemiparesis. Of these survivors, fewer than 10 per cent ever get to a residential rehabilitation centre. The corollary is that at least 90 per cent of patients with stroke are managed in the community.

One third of survivors of major stroke have serious communication difficulties, but speech therapy departments are limited. One study (Meikle *et al.*, 1979), despite the unfortunate lack of a control group, found no difference in outcome between a group treated with qualified speech therapists and another treated by non-professional volunteers. Moreover, since recovery from stroke is spontaneous, and depends heavily on factors such as age, severity and associated disease, it has been difficult to show convincingly that rehabilitation and the efforts of therapists are effective and, hence, justifiable. Others (Litman, 1966; Overs and Belknap, 1967) have emphasized the place of the family in rehabilitation and chronic illness. What is certain is that, although the contribution made by relatives of stroke patients who are cared for in the community is enormous, it is not made without a significant toll on their health and disruption of their lives.

Hospital management

It is appropriate in most cases that the first phase should be managed in hospital, where high technology care, such as blood gas monitoring, IV feeding and investigation, are accepted as being part of general medicine. The second phase of rehabilitation is often less satisfactory. There is a need for specialized stroke units which can manage rehabilitation through group activity and competition. Units such as these can be found only in large cities, but their creation has begun to answer the question, frequently asked: "Is active rehabilitation effective?" A study of the new Greenwich stroke unit (Blower and Ali, 1979) emphasized the importance of a team under consultant leadership, and the authors were convinced that the intensive therapy provided in the unit did more for patients than managing rehabilitation in general units. Last year, trials carried out from Northwick Park Hospital and with large enough numbers of patients to produce significant results showed that, provided criteria for exclusion are reasonably rigorous, conclusions based on the Aids to Daily Living as a measure of outcome indicate that intensive outpatient treatment is probably a realistic policy within NHS resources. Even in the elderly (Garraway *et al.*, 1980), a significantly higher proportion of patients can be discharged from the acute stroke unit having achieved independence when compared with patients discharged from medical units.

General practice management

The principles of stroke rehabilitation in the home are now well known, but applied at random. Since improvement may continue for five years after stroke illness, the general practitioner is in the best position for continued supervision. The increase in the number of geriatric day centres brings almost every patient within reach of an enthusiastic multidisciplinary team, where physiotherapy, occupational therapy and psychometric evaluation are available. There may well be a case for developing, in addition, mobile stroke teams which could be directed at short notice to households where there are patients with fresh strokes of moderate severity. Perhaps one of the most important single functions of such teams would be to provide an effective counselling service, particularly in relation to speech and difficult behavioural problems. The attention of the primary care team should be directed particularly to the problems experienced by the chief carers, a majority of whom will have significant health problems of their own, and/or further responsibility for the care of others (Brocklehurst *et al.*, 1981).

The general practitioner can do much simply by never being entirely satisfied. There is always a danger of regular visits becoming occasions merely for the patient to demonstrate his or her progress, or at worst for tea and sympathy. While the doctor must provide motivation and encourage the patient to make great efforts, it serves no useful purpose to do so in ignorance of the patient's cognitive function. Furthermore, over-concentration on the plegic aspects may obscure the need to attend to the patient's nutritional status, cardiac function or the correction of such features as urinary tract infection and anaemia. Above all, patients can compensate for loss of power far better than for proprioceptive loss or inco-ordination.

Finally, patients and carers alike may benefit considerably from the development of a stroke club (Millard, 1976). A major campaign sponsored by the Chest, Heart and Stroke Association has led to almost 400 clubs being set up in Great Britain. Many of these are held on the premises used by general practitioners with transport provided by volunteers; they form part of the more conscious effort to include the relatives of patients in their work.

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