

The general practitioner and the disabled

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SUMMARY. The results are presented of a questionnaire survey testing opinion about care for disabled patients. Most respondents agreed that the disabled in the practice should be identified. The views of the doctors as to the possible methods of identification and how the information might be used are given. The point is made that further in-depth studies are necessary to determine the characteristics of practices with information systems and whether there are benefits to patients attending a practice with such facilities.

Introduction

THE year 1981 was designated the International Year of the Disabled and, *inter alia*, stimulated discussion about the standards of care that should be provided for disabled people in the community. Many questions were raised. Who are the disabled? Does a general practitioner know about those in his practice? How far should a general practitioner go in formally identifying his disabled patients? What are the attitudes of general practitioners towards the disabled?

In order to find the answers to some of these questions a survey was undertaken of a one-in-five sample of general practitioners who were Members or Fellows of the North West Faculty of the Royal College of General Practitioners. Two hundred questionnaires were distributed and 126 (64 per cent) replies were received. Table 1 shows that the age and sex distribution of the respondents was similar to that for all general practitioners in 1977 but that they were less likely to be in single-handed practices (DHSS, 1978).

The general practitioner's perception of the disabled

The response to the questionnaire brought into sharp relief the problem of defining disability. A definition was given in the questionnaire, but when the modifica-

Table 1. Sex, age and general practice type distribution for the survey study group and all general practitioners in England in 1977. (Percentages are shown in parentheses.)

| | Study group | General medical practitioners |
|---------------|-------------|-------------------------------|
| Sex | | |
| Male | 112 (87) | 17,867 (85.9) |
| Female | 16 (12.5) | 2,929 (14.1) |
| Age (years) | | |
| 20-29 | 9 (7) | 1,612 (7.7) |
| 30-39 | 31 (24) | 5,546 (25) |
| 40-49 | 31 (24) | (27) |
| 50-59 | 38 (30) | (26) |
| 60+ | 19 (15) | (14) |
| Practice type | | |
| Single handed | 9 (7) | 3,419 (16) |
| Group | 119 (93) | 17,377 (84) |

tions suggested by the respondents were included the following emerged:

'A disabled person is one who, at any age, is suffering from a permanent impairment of such a degree that it significantly interferes with the normal functions of life.'

This leaves subjective judgements to be made about the words 'significant' and 'normal' but can be accepted as a practical working definition. The responding doctors thus regarded disabled patients as being those whose impairment produced a handicap, the key being permanent functional defect. This conforms with the WHO continuum of impairment, disability, and handicap (WHO, 1980), although in this paper the terms disabled is retained because of its common usage.

When asked for the proportion of their patients that they considered to be disabled, 81 per cent of the responding doctors thought it was less than 15 per cent. Table 2 lists the conditions mentioned spontaneously in response to the question 'Which specific group of patients do you regard as disabled?' Included in the group 'other' was the disability caused by social impairment (whether environmental, economic, cultural or educational).

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Table 2. Respondents' perception of disability expressed as a percentage of responses mentioning each disability category ($n = 128$).

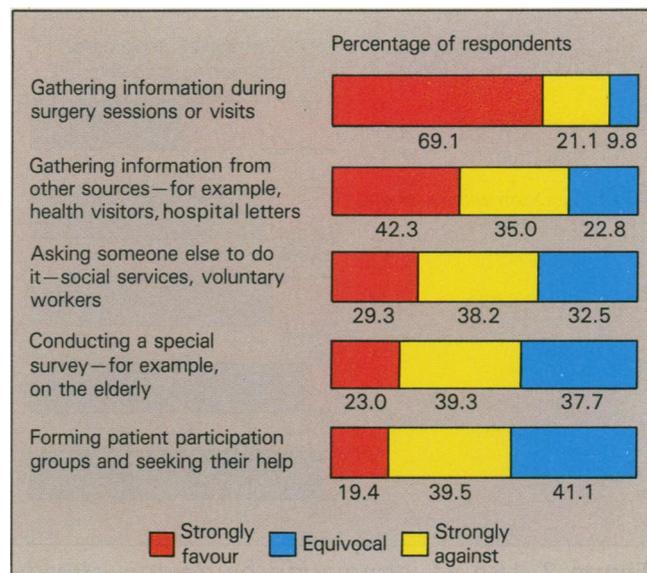
| Disability | Extent of disability | Percentage |
|------------------------|--|------------|
| Blindness | Complete or partial | 77.3 |
| Mental problem | Congenital or acquired incapacity. Mental illness | 76.6 |
| Mobility problem | Arthritis of all types. Housebound old person | 76.6 |
| Deafness | Complete or partial | 64.1 |
| Cardiovascular disease | Heart failure, angina, claudication | 56.3 |
| Respiratory disease | Obstructive airways. Chronic bronchitis | 52.3 |
| Stroke | With permanent sequelae | 51.6 |
| Congenital defect | For example, spina bifida, cerebral palsy | 50.8 |
| Neurological disease | For example, multiple sclerosis, Parkinsonism | 42.2 |
| Other | For example, diabetes, epilepsy, renal failure requiring dialysis; having a colostomy or ileostomy | 39.8 |
| Amputation | — | 33.6 |
| Effects of injury | — | 21.1 |
| Incontinence | Urinary or faecal | 5.5 |

Identification of disabled patients

As might be expected, most of the responding doctors thought it was a good idea for general practitioners to know about their disabled patients and over half considered it was the doctor's duty to take positive steps to identify those in his practice. (The word 'duty' was deliberately used in the questionnaire to test the strength of opinion and commitment.) Slightly more than half thought that the health visitor should be involved in the process. Only a few felt that receptionists had a part to play in the identification of the disabled, but more than a third considered that other agencies such as Social Service Departments could be a useful source of information.

About one in three of the respondents were already recording some groups of disabled patients within their practices. Nineteen were using a disease register (including three who were using an E-Book); eight had either a register confined to specific disabilities or used a colour code to indicate disablement.

The methods of identifying the disabled mentioned most often by this group of respondents were: during patient-doctor contact: by information received from

**Figure 1.** Identifying the disabled: percentage of response to specific methods of identification ($n = 115$).

other members of the primary health care team; and by screening sessions—for example, at antenatal, family planning and developmental assessment clinics. This would emphasize the fact that disablement can occur at any age, and even *in utero*.

Nearly two thirds of respondents were in favour of setting up a Disability Register. They were also asked to give their views about five specified methods of identifying disabled patients. The results are shown in Figure 1. The most popular method was during doctor-patient contact.

Value of identification in improving care

Many respondents questioned the value of the information gained by identifying the disabled and the use that could be made of it. As one doctor put it: 'Having gathered the information, what then? It will be of little value unless there are facilities to help the disabled'.

Those respondents who already possessed a register of disabled patients were asked how useful it was to them; their answers are summarized in Figure 2. The category 'periodic assessment' included various forms: some doctors use the information for deciding the priorities for home visiting by doctors or other members of the team; others merely reviewed the records periodically; some used information in relation to a recall system, for example, for patients being treated for hypertension. No doctor defined precisely how often assessment or review should take place.

The doctor's sound knowledge of the disabled people in the practice was useful in discussion and information-sharing within the practice team. It was of value in arranging referral to other agencies, such as Social Service departments, Housing departments, voluntary

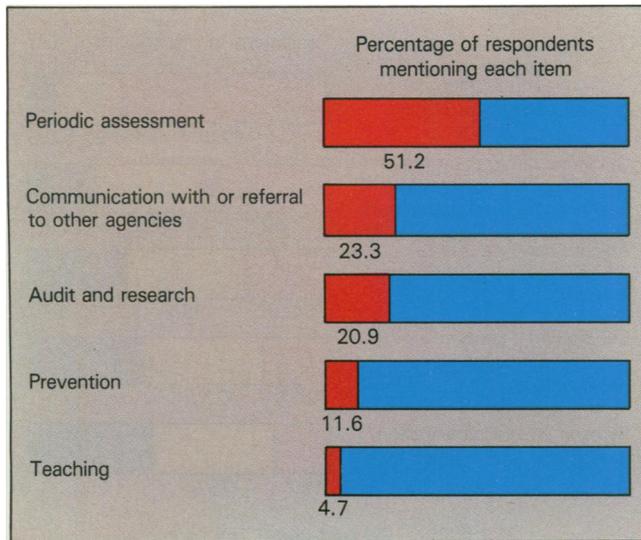


Figure 2. Use of information by doctors already identifying the disabled expressed as a percentage of respondents mentioning each item ($n = 43$).

organizations and hospitals. Most respondents agreed that early recognition of need among specific groups, particularly the elderly disabled, was important in anticipating care. Influenza immunization was mentioned as a specific preventive initiative.

The value of the information for audit and research was mentioned by about one fifth of those with information available about their disabled. Many of the same doctors used the information as an easy way to find 'cases' for teaching purposes. One doctor mentioned particularly the benefit of knowing about patients who were coping well, because they were excellent sources of information for the newly disabled.

Doctors who had no system of recording the disabled were asked how they would use such information if it were available. Only one third supported the view that it would facilitate regular health surveillance by general practitioners. Three fifths of the respondents would only undertake medical review if asked to do so by the patient. However, over three quarters supported the idea of regular review of the patient's health and environmental situation by health visitors.

The elderly

A question about the value of screening revealed a considerable diversity of opinion. Thirteen of the doctors already had screening sessions for elderly patients. The remainder were asked whether they would be prepared to undertake this type of screening. Figure 3 shows that the balance was fairly even, but only 13 doctors were strongly in favour of screening their elderly patients and twice as many were strongly against. Comments included such points as problems of workload, time and finance. Several doctors pointed

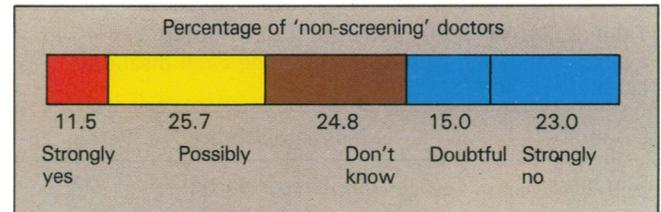


Figure 3. Response of non-screening doctors to question of holding screening sessions for the elderly.

out that screening clinics should be funded in the same way as contraceptive advice—on a fee-for-service basis. Some respondents recognized a need for screening but were unsure of their own commitment to it; others wanted to be convinced of the practical usefulness of screening.

Discussion

In general practice it is not easy to reach a consensus about what constitutes good care. This survey was an attempt to gain general practitioners' views about their responsibilities towards the disabled. Most respondents gave thoughtful answers and provided useful additional comment.

Although the perception of disability was variable, there is a deep interest in disabled patients, and concern to identify the disabled showed this. However, it was repeatedly stressed that disabled patients wish to be treated as normal people and would dislike searching initiatives such as screening. These reservations were strong even in the case of the elderly disabled. The respondents commented that there may be two types of disabled patients: those who could be classified as 'the fortunate' disabled who had adapted to their handicap often in an impressive way, and the less fortunate remainder who were particularly in need of help, although most of the latter would be known to the practice. However, there was concern that the needs of some disabled people could be overlooked since in large group practices the patients were often seen by different doctors who think that others are taking action. The value of a team approach in these circumstances was stressed, especially the contribution of the health visitor.

The opinions which emerged from analysis of the questionnaires showed that the doctors favoured the following action.

1. It should be part of practice policy to agree a definition of the disabled.
2. A disability register should then follow.
3. Identification of the disabled; this would most often be obtained during doctor-patient contact.
4. The disability register would be used to offer the patient periodic review by a doctor and regular surveillance by a health visitor.

5. The register would be an aid to audit, teaching, the education of other patients, and would facilitate preventive measures.

How would these ideas work in practice? The disability register would clearly be a disease register with special features. Essentially it would consist of a few specially selected conditions chosen by the team who were to use it. To collect the information would involve the whole team, and receptionists could gather information when patients first registered with the practice. Letters from consultants about new patients, the local Social Service Area Office, and voluntary bodies would all be valuable sources of information. Contacts could be developed with other community workers, for example the clergy, who may be knowledgeable about the disabled in the area.

The contribution of patient participation groups is as yet unknown. It might be that they could develop a special interest in the disabled in the practice.

Will information about the disabled be of real value? The doctors with existing systems of recording their disabled patients found it to be so. They considered regular patient assessment aided by a disease or disability register and more efficient patient care. Many found the information essential for audit, teaching and initiating preventive procedures. Doctors without information systems showed some interest in periodic review but were much firmer in their support of health visitor involvement in this area, although they supported the idea of a disability register.

The question is raised, however, as to whether there are advantages for patients attending a practice with a disability register or screening policy. This is still unknown. The questionnaire study points to the need for a deeper exploration of the benefits to patients of a practice information system.

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