How general practitioners can help carers' support groups

Sir,

During a three-month locum in a semi-rural practice in north west Leicestershire, I attended the fortnightly meetings of a carers' support group which had been running for 10 months. It was set up and run by members of the local social services, with help from the doctors in the practice in whose premises the meetings were held. The carers were all women, mostly in their fifties and sixties, looking after husbands (usually) with mainly chronic physical disabilities. The group's objectives were to provide eduation and emotional and social support to others in a similar situation.

The carers determined the content of the meetings. Both the professionals and the 12 to 15 carers who attended regularly felt that the group was a success, especially in counteracting the carers' loss of status and independence.

With the growing numbers of elderly and chronically ill in the community, there is an increasing burden on their carers. These people have their own needs, including adequate recognition of their work and status by the community, information, planned 'breaks' away from their charges and continued support.[1] These can be served at least in part by carers' support groups. My own experiences suggest that, as members of the primary care team, general practitioners are in an excellent position to help these groups by:

- Identifying and approaching those carers who might benefit.
- Providing a venue in their premises for the group to meet, thus increasing the group's acceptability and status.
- Acting as an education resource.
- Using their knowledge of each carer to recognize their individual needs, thus identifying areas where they or others might help.
- Increasing recognition of the special status of carers by providing support and by becoming advocates on their behalf.

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Reference

1. Anderson R. The unremitting burden on carers. *Br Med J* 1987; **294**: 73.

Physiotherapy in the community

Sir,

I read with interest the article on physiotherapy in the community (May *Journal,* p.194). I have never seen a physiotherapist attend any patient of mine or my colleagues in the community, nor indeed have I ever seen a physiotherapist attend patients occupying beds in some of our local geriatric hospitals.

I have always felt that physiotherapists could train interested nurses so that at least patients with respiratory disorders could, where indicated, be treated with postural drainage and breathing exercises. This could be life saving in so many cases.

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Integration of community medicine and primary care

Sir,

The green paper, *Primary health care — an agenda for discussion,* consciously excluded a public health dimension from its remit. Subsequently the House of Commons Social Services Select Committee drew attention to this omission but they in turn proposed a very restricted and 'safety net' role for our community health services. It was refreshing therefore to read Dr Stone's appeal for a greater integration of community and primary health care services (May *Journal,* p.218).

He points out that in the last decade the College has given a lead in promoting a strategy which places increased emphasis on planned anticipatory care in continuing and preventive health. But in the organization, administration and evaluation of these services to defined populations we have been found lacking. Those practices who have successfully grappled with this problem have been re-inventing the community health care wheel. Even at this level, therefore, an integration of community and primary health care would be well worthwhile.

Furthermore, there has emerged an increasing body of evidence in recent years which highlights the differing health status between and within countries and societies. The implications of this for prevention and continuing care reach far beyond that of individual high-risk identification; it demands a population based approach.

Many of the solutions at this macro level are in the political and economic domain. But they also have medical and public health implications which we as primary health care professionals must be able to confront. We can choose to do this in our traditional isolated way and blame the ill for smoking, eating and drinking too much. Alternatively, we can recognize that a total approach must include a major public health dimension which should be part of integrated primary health care.

Dr Stone is correct in stating that there are many ideological and administrative difficulties in the way of an effective integration of community and primary health care at this stage. We have tried to come to grips with some of them. In the Medical Practitioners' Union document, *The future organisation of primary health care,* we propose a number of models to allow this integration to take place and have recommended that they be evaluated on a pilot basis.

We believe that this critical and scientific approach will provide a more satisfactory basis for the primary health care service to look after the individual and collective needs of our patient population.

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Sir,

Dr Stone's paper (May *Journal,* p.218) is helpful in highlighting the contrast in orientation between community medicine and general practice, and in indicating the need for combining a population-based with an individual-oriented preventive strategy. We support this trend but consider that general practitioners will need help and guidance in adopting a broader approach. Community physicians are thin on the ground and usually relate to a whole district rather than to practice-sized patches. However, community paediatricians combine an individual child approach with a population perspective, and are dedicated to promoting integration of child health services. They would be well placed to provide back-up for practices in looking at their child population's health needs. Some practical examples of a population-preventive approach in general practices are:

- Child health surveillance of the practice population's children.
- Identification of target groups in the practice population for preventive intervention (for example, stress management in smokers).
- Data collection in the practice population with respect to immunization, child abuse and accidents.

We feel that general practitioners are likely to adopt a broader preventive approach if offered support and resources in areas such as these.

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