and much nearer the general practitioner. However, it is by the increasing entry of the Ministry of Labour's disablement resettlement officers to the hospitals that the ultimate final resettlement of patients will take place.

There are gaps in this picture. There is the gap, for example, between the general practitioner and the consultant at the hospital, so that the general practitioner is not informed that his patient is due for discharge and what arrangements have been made for his follow-up and for his resettlement or reabsorption in work. There are other gaps, such as the gap Dr Cooksey referred to within a most careful and brilliantly conceived scheme which he has developed for those sick people whose disabilities must deteriorate as the years go on. As a profession it is our duty to try and fill these gaps, bring together the health services and all that they represent, without which the ultimate resettlement of the rehabilitated patient will be quite impossible. Perhaps in the future the industrial rehabilitation units of the Ministry of Labour should come closer to the hospital services, as contemplated in Glasgow, where an industrial rehabilitation unit is to be built within the compound of a big general hospital. There might be side by side with the industrial rehabilitation units and government training centres a medical reablement centre controlled by the Ministry of Health through its peripheral agencies. All these experiments may have to be contemplated. I think the most important consideration is that whatever pattern emerges, it should be one in which overlapping is avoided and in which economies can be maintained.

DISCUSSION

Question: As far as I can see, there is nothing in the law at the moment which helps these people economically, because a lot of them can get more money by not working than by working; psychologically this is bad. Do you think that the only answer to this situation is to produce new Acts?

Sir Harry Platt: That may be the answer, but it is a bold assertion to make. I have heard of individuals here and there, even paraplegics in a well-known centre in the north of England, who are not tempted to go out to work by the allowances which the labour exchanges, through the disablement resettlement officers, have arranged. My friend Mr Guttmann may come across such a

patient occasionally, but for the most part he seems to have inspired his paraplegics with a tremendous zest for remunerative work. I suppose that regulations could alter the allowances without a new Act, but I do not know.

Question: Do you find that the time interval since the onset of disease has any influence on the time when the patients are actually fit to go to work?

Sir Harry Platt: I should imagine that all the speakers would agree that, the more prolonged the illness and disability, the greater the weakening of the will to recovery and the will to get back to work.

Mr Guttmann: I would like to endorse what Sir Harry has just said. A group of people come to us in a good physical condition but completely demoralized by enforced inactivity in other hospitals, and these are the most difficult to deal with. There are two psychological reactions to inactivity. One is increased irritability; everybody knows that if one is at home for a long illness or even for a long holiday one gets irritable and the first sufferer is the wife. Increased irritability is a good reaction, because it is the fight of the organism and the brain against sinking back into disability. The other reaction is apathy. We have observed not only in disabled people but in prisoners of war and inmates of concentration camps that it is extremely difficult to determine whether they are disabled, or normal people who have been kept in enforced inactivity.

Dr McKenzie: I feel that anyone who is disabled, particularly if severely disabled, is quite entitled to have a living wage whether he is going to work again or not. Surely it is a reflection on the medical profession if rehabilitation fails to the extent that we do not inspire this person to go back to work again. As Dr Cooksey has said, patients say that it is not the money they want but the work; very few do not go back to work simply because they get more money by sitting at home and doing nothing.

Dr Morgan: All doctors should work in general practice first, and then they would realize that there is a psychological reaction to money. I would like Dr McKenzie to tell me how she gets over this psychological reaction. I want the disabled to be paid more than they can get on National Assistance.

Dr Sommerville: In actual fact, the disabled person can earn at least up to £1 a week on top of his benefits without making any difference to the benefits. This is not generally known. In some areas the earnings can go up to about 30s., and in one area to £2 without upsetting the statutory benefits. These are positive incentives to the patient to work and to make a bit more pocket-money than he would otherwise have. The key problem is a deeper one: the people who have become disabled unemployables are the people

who have been neglected earlier on, and as somebody once said: "The disabled unemployables are the people who have been suffering from a planned programme of medical neglect".

Dr Cooksey: I don't think this is quite right, because I think you will find that if a man earns £1 or 30s. a week and is on Public Assistance, the latter will be cut.

Chairman: That is quite right.

Dr Cooksey: The problem is bureaucratic constipation. As Miss McKenzie knows perfectly well, in my department for the last two years I have had a partial quadriplegic who works hard at wood and metal work and whose income from various benefits (he is a married man with two children at a grammar school) is £11 10s. 0d. a week. We got him, with a struggle, placed in a Remploy factory where his wage is £8 13s. 0d. a week. Because various National Assistance supplements, etc., for assisting his education when he is unemployed and disabled stop when he starts earning, he would drop £3 a week if he went back to full-time work. That man, in fact, was prepared to go back to full-time work, but at that stage I persuaded the Ministry of Labour to let him have a tricycle, and it meant that the Ministry of Labour provided another £7 a week supplement to get him to work, as they had powers to do and were prepared to do. I thought that this was really going a bit too far. He lost £3 a week for a full-time week's work, it cost the Ministry of Labour £7 a week to get him to work, and we all know that the subsidy to a place in a Remploy factory is £9 10s. 0d. a week. I thought this was unrealistic, and so for the moment he is still making very useful appliances in my department. This is the whole crux: once the disabled man goes to a sheltered workshop where the rates are low, he is worse off than if he continues on the sick list.

Question: I have found from my experience that it is possible in a large organization to get a man back on part-time work (ten till four); it is quite a simple job, and it is often quite easy with a small family organization where they are very glad to get a person back on two-thirds work. The difficulty occurs in some of the smaller factories and the smaller industrial organizations, where the brotherhood of man does not seem to exist, and the other workers won't tolerate 'carrying' a fellow for a short time. Is there not a great deal of difficulty in getting a man back into industry because his mates won't accept him on a part-time job?

Question: Is it not true that many of us in clinical medicine are faced with the defence mechanism of denial? By this I mean that many able-bodied persons find it difficult to work cheek-by-jowl with the disabled, the crippled and the amputee, especially as many are reminded by working with disabled persons (especially with the so-

called ' ugly disabilities ') of the fact that life is not a gift and that they are fragile human beings. It may be that psychological factors often make it difficult to reabsorb colleagues into their old factories. Of course, there is legislation which lays down that a statutory three per cent of employees in large firms should be disabled, but should we not also bring in the patient's family, his spouse perhaps, to discuss the personality of the patient in regard to his injury? Certain parts of the body have an emotional symbolic significance for the patient, and often he may feel that his body-image has been uglied or injured by the injury.

Mr Guttmann: This is true, and this is where we have to educate the employers. The employer sees a man in a wheelchair and sees only what he has lost; he does not realize that that man can be a much better worker than ten of his best able-bodied workers. But I think we are quite wrong in saying that there is hostility or a psychological attitude of denial of able-bodied workers towards the disabled. From our past experience with many people working full-time for many years I can categorically say that this is not true. On the contrary, the worker very soon develops comradeship towards the disabled person and will help him; moreover, it has been proved again and again that the absenteeism of severely disabled people such as parapletics is no greater than that of the able-bodied—on the contrary, they don't ask for certificates for headaches and sore throats because they feel a greater responsibility towards their work than many able-bodied people.

CHAIRMAN'S CLOSING REMARKS

Dr Fraser Rose: I would like, as president of the College of General Practitioners and as a general practitioner, to put the general practitioner's point of view in this matter. We are in some sense a little divorced from these cases, because so often their injuries or acute diseases have hospitalized them and they do not come back to us until a much later phase, but nevertheless we have a part to play. Our part is one of encouragement and of guidance.

I think that we should congratulate ourselves this afternoon on the very high level of papers that have been delivered. We have not been blinded by science; the material has been kept at a level that is within our easy comprehension. There have been no elaborate processes put in front of us, and I think that that is only right and proper. This symposium is illustrative also of the unity of purpose of physicians, surgeons, physiotherapists, occupational therapists and so on in devising ways of overcoming disability and of making the best use of remaining abilities; that of course is the essence of the