

Are they being served?

Late last year a survey by the Consumers' Association drew attention to the continuing plight of the disabled in our community.¹ Many were unaware of the facilities available and were not receiving services that would have helped them. Clearly the intentions of the Chronically Sick and Disabled Persons Act (1970) have often failed in practice.

The Act required local authorities to number their disabled and chronic sick to provide both information and services. An Office of Population Censuses and Surveys survey in 1971 showed that in Britain 1.1 million people over the age of 16 in private households were appreciably or severely handicapped—about 3% of that population. Of these, 150 000 were unable to use part of their home because of disability, 90 000 were living alone, and many were not receiving services.² The quality of local authority surveys made since the 1970 Act³ has been variable, but two well-conducted surveys,^{4 5} in Canterbury and Leeds, have shown that a substantial proportion of handicapped people living at home were in need of a telephone, chiropody, help with housework, and aids and adaptations. Those living in rural areas may be better off: a recent study in Hereford and Worcestershire concluded that low referral rates to social services reflected the greater commitment of family and friends.⁶

Commenting on the poor delivery of both employment services and social services to patients with multiple sclerosis or paraplegia Johnson and Johnson suggested that difficulties in obtaining these services might be even greater for those with less overt disability.⁷⁻⁹ But these are infrequent causes of disability: in a community of a quarter of a million (the size of Plymouth) there would be 140 people with multiple sclerosis or paraplegia but well over 10 times as many severely disabled from arthritis or cardiovascular disease.¹⁰ The effects of the commoner disorders may not be as catastrophic but the needs of affected patients must not be forgotten. The two overriding questions are how can services be made accessible and available, and how can the anonymous be ascertained?

Nichols's definition of rehabilitation as the "physical, social, psychological and organisational aspects of aftercare of patients needing more than short term definitive treatment"¹¹ necessarily embraces a daunting range of services. Patients should have access to a comprehensive service to meet all their needs: even altering the position of an electric point, for instance, may make a big difference to the life of a patient with a locomotor handicap. In many areas there is no one person directing

rehabilitation services and responsibility for individual patients falls—in the first instance—on their general practitioners. Yet both hospital and family doctors are often unaware of the implications of the 1970 Act, and many believe it is not their function to assess the "social" needs of patients: in one study only two of 194 patients with health-related problems were referred to social workers by their general practitioner.¹² Seven years ago the Seebohm Report drew attention to the poor co-operation between medical and social services and emphasised that general practitioners, who were in touch with more of those in need than anyone else, were in the best position to refer.¹³ The family doctor's importance as first point of contact cannot be overemphasised: the Office of Population Censuses and Surveys survey showed that nine out of 10 handicapped persons had seen their general practitioners within the last year.² The Consumers Association found that one in 10 had contact with only one person—and in every instance this was the family practitioner.¹ Clearly the disabled patient's welfare has to be the family doctor's concern,¹⁴ but hospital discharge letters should mention further services. Apparent neglect can stem from other professionals: many isolated visits from social workers are never followed up.⁶

Doctors need to be aware, then, of the range of services available. Apart from those provided by the NHS, a mass of supporting services is provided by central and local government sources: the DHSS (artificial limbs and appliances, mobility schemes); the Department of Employment group (Manpower Services Commission's rehabilitation, resettlement, and training services; Health and Safety Executive's Employment Medical Advisory Service); local government social services (home adaptations, aids to communication and mobility, home help, chiropody, recreation); education and career services; and voluntary organisations.¹⁵⁻¹⁷

How can we help our patients better? General practitioners are busy and many have no health visitors or other staff. Social workers need to get to know general practitioners and work closely with them; Reedy has drawn attention to the vital function of the secretary in identifying cases,¹⁸ though Warren thought that general practitioners' records were unlikely to contain adequate notes on handicap.¹⁹ But the practice secretary can surely flag patient records to identify known difficulties (living alone, mobility problems, work problems, severe sensory loss, housebound, artificial aids or appliances). Each category could then be reviewed regularly with referral to the

appropriate service; this would encourage future noting of handicaps. The onset of new illness would renew contact with the general practitioner.

Many practices already display posters and pamphlets; group practices and health centres may hold regular clinics for patients with specific handicaps at which an ancillary worker could be present. But local authority social services are under great pressure, and their high turnover of young and inexperienced social workers may cause difficulties. Ideally there should be one named contact in the social services department for inquiries from primary care teams.

An outstanding concern is returning patients to work, and many could be assessed for their work potential much sooner. The best boost to treatment a doctor can offer is a return to work before depression has set in, and referral to the disablement resettlement officer (who can also arrange aids or adaptations at work under various schemes) is often of help. But the resettlement services are basically unaltered since the last war, and many difficulties face those who need further advice.¹²⁻²⁰ Where there is an option of return to the former employer, early medical contact should be made with the physician in charge of the occupational health service concerned or with the employment medical adviser. Though there has been a limited trial of hospital-based resettlement officers, there is still no hospital vocational "counsellor,"²¹ and hospital medical staff should always bear this aspect of outcome in mind.

How can we find the "hidden" handicapped? Warren has suggested using household questionnaires.²² Could not electoral returns include a card to be posted to the social services department if a visit were needed? Government publications (such as leaflet HBI—"Help for Handicapped People") could be made more readable and sent to every household, while more use could be made of television and radio to indicate the help available and urge those not known to the services to get in touch. Details of information and help available nationally are useful mainly for reference—one "ABC" covers 84 closely written pages,²³ while a recent bibliography of sources of information for the handicapped and elderly lists 114 separate publications.²⁴ Local information is of more practical use, and many authorities produce their own excellent guides.²⁵ Expansion of local telephone advisory services (many manned by disabled people) is one way to overcome individual reluctance to consult large anonymous departments.²⁶

We are still a long way from the ideal of universal services and from schemes such as a holder's "handicap passport"²⁷ or from a high street system of advice and delivery. Economic stringency has combined with common sense to develop and improve existing services,⁶⁻²⁸ while emphasis is rightly being given to the importance of both local links and a first point of contact in whatever guise.²⁹ The accepted strategy is to move long-term health care into the community, but the tactics of its delivery are all important. The *Which?* Report has reminded us that the shopping basket for the disabled which the 1970 Act aimed at providing is often empty, and that the medical profession can play a vital part in helping society to deliver their patients' best buy.

¹ Consumers' Association, *Managing at Home, Which? Campaign Report*. London, Consumers' Association, 1978.

² Office of Population Censuses and Surveys, *Handicapped and Impaired in Great Britain parts I and II*. London, HMSO, 1971.

³ Brown, M J, and Bowl, R, *Study of Local Authority Chronic Sick and Disabled Persons Surveys*. Birmingham, University of Birmingham Social Services Unit, 1976.

⁴ Research and Planning Section, *Survey of Handicapped and Impaired Persons in Leeds County Borough*. Leeds, Leeds City Treasury, 1973.

⁵ Warren, M D, *The Canterbury Survey of Handicapped People*. Canterbury, Health Services Research Unit, University of Kent, 1974.

⁶ Taylor, H, *Social Services Provision in a Rural Area*. Birmingham, University of Birmingham Social Services Unit, 1977.

⁷ Johnson, R H, and Johnson, G S, *British Medical Journal*, 1972, **1**, 779.

⁸ Johnson, G S, and Johnson, R H, *Lancet*, 1977, **1**, 31.

⁹ Johnson, G S, and Johnson, R H, *Living with Disability*. London, Churchill Livingstone, 1978.

¹⁰ Badley, E M, Thompson, R P, and Wood, P H N, *International Journal of Epidemiology*, 1978, **7**, 145.

¹¹ Nichols, P J R, *Rehabilitation Medicine in the United Kingdom*. Seminar on Rehabilitation for the Disabled, Strathclyde University, 1978.

¹² Blaxter, M L, *The Meaning of Disability*. London, Heinemann, 1976.

¹³ *Report of the Committee on Local Authority and Allied Personal Social Services*, Cmnd 3703. London, HMSO, 1972.

¹⁴ *British Medical Journal*, 1978, **2**, 847.

¹⁵ Topliss, E, *Provision for the Disabled*. Oxford, Blackwell, 1975.

¹⁶ Mattingly, S, ed, *Rehabilitation Today*. London, Update Books, 1977.

¹⁷ Central Office of Information, *Care of Disabled People in Britain*, pamphlet 131. London, HMSO, 1975.

¹⁸ Reedy, B E L C, in *Trends in General Practice*, ed J Fry, p 111. London, British Medical Association, 1977.

¹⁹ Warren, M D, *Rheumatology and Rehabilitation*, 1977, **16**, 248.

²⁰ Martin, J, and Morgan, M, *Prolonged Sickness and the Return to Work*. London, HMSO, 1975.

²¹ Brewerton, D A, and Nichols, P J R, *British Medical Journal*, 1977, **2**, 1006.

²² Warren, M D, *Handicapped People in the Community*. Canterbury, Health Services Research Unit, University of Kent, 1975.

²³ MacMorland, B, *An ABC of Services and Information for Disabled People*. London, Disablement Income Group, 1976.

²⁴ DHSS, *Sources of Information for Handicapped and Elderly People*, Bibliography Series B 104. London, DHSS, 1978.

²⁵ *Services for Handicapped People in Brent*. London, London Borough of Brent, 1977.

²⁶ Disabilities Study Unit, *Look Back at Tunbridge*, ref 3/77. Arundel, Disabilities Study Unit, 1977.

²⁷ Department of Health and Social Security, Department of the Environment, Discussion paper, *The Disabled Worker*. London, DHSS-DE, 1978.

²⁸ Taylor, D, *Physical Impairment: Social Handicap*, report no 60. London, Office of Health Economics, 1977.

²⁹ *Sunningdale Seminar on Disablement*, progress report. London, DHSS, 1978.

Management of refractory oedema

Oedema is rarely refractory to diuretics. Apparent resistance usually reflects faint-hearted dosage or failure to harness simultaneously the different actions of several groups of diuretics. Planning a phased introduction of diuretics and patience in achieving a controlled diuresis are the first essentials for treating difficult oedema; with this approach reluctance rarely becomes resistance. Though sometimes useful, mechanical methods of shifting oedema tend to mean that the doctor does not fully exploit the simpler and safer combined diuretic treatment.

Dual diuretic treatment starts with a loop diuretic, such as frusemide, and spironolactone. The dose of frusemide should if necessary be increased to as much as 2 g daily, though this is an exceptional need. Deafness, however, is a risk of prolonged high dosage, while hyperuricaemia sufficient to cause acute gout and sometimes to endanger renal function may result from much lower dosage. Spironolactone (in divided doses of at least 300 mg daily) normally prevents hypokalaemia and produces additional diuresis by competitive inhibition of aldosterone. Large doses of frusemide are effective even in advanced renal failure, promoting excretion of up to 87% of filtered sodium.¹ In general, few diuretics in large dosage are preferable to several in low dosage, but if nausea limits the dose of one loop diuretic a second (such as ethacrynic acid) should be added.

A poor response to diuretics is sometimes a sign that the oedematous intestinal mucosa is not absorbing them properly