Industrial Rehabilitation

STEPHEN MATTINGLY,* T.D., M.B., M.R.C.P., D.PHYS.MED.

Brit. med. J., 1965, 2, 930-932

Twenty-one years ago, when the Allies were preparing to land on the Normandy beaches, Parliament passed an Act which established the right of disabled men and women to work. Their services had proved invaluable in war, when man-power was short; their interests were to be protected in peace.

This year the Ministry of Labour is celebrating the twenty-first anniversary of the passing of the 1944 Disabled Persons (Employment) Act, which in 1965 is still the keystone of industrial rehabilitation. It is a fitting time to take stock. What has been achieved so far? What remains to be done?

After the first world war disabled ex-Service men had been trained in the Ministry of Labour's training centres for new jobs, and the King's National Roll scheme had been introduced in 1919 to encourage employers to employ a quota of disabled ex-Service men; but the Act of 1944 was far more comprehensive and applied not only to ex-Service men and women but to all the disabled. Ernest Bevin, who was Minister of Labour in 1941, had introduced an interim scheme for the retraining and resettlement of disabled people to help the war effort, and later in the same year the Tomlinson Committee was set up to make recommendations for a permanent service. Its findings were incorporated in the 1944 Act. This required the Minister of Labour to maintain a register of disabled people and to help them find work; certain jobs were reserved for them, and employers were required to employ a quota of registered disabled workers; sheltered employment was to be provided for those most severely handicapped, and courses of industrial rehabilitation and vocational training for those who could compete in open industry.

Disabled Persons Register

The Disabled Persons Register is kept at every employment exchange. All those who are disabled as the result of injury, illness, or congenital deformity can apply for registration provided that they are of working age, that the disability is likely to last for at least 12 months, and that they have some reasonable prospect of getting a job.

At present one in forty of Britain's working population, just over 650,000 men and women, are registered as disabled (see Table). Of these, 50,000 are unemployed, but many are capable

Some Rehabilitation Statistics

1965		
Working population		24,000,000
No. on Disabled Register		655,000
Unemployed		43,000
In sheltered employment:		
(1) Remploy		7,000
(2) Other workshops		6,000
1944-65		
Jobs found for the disabled		over 2,000,000
Completed course at I.R.U.		134,000
Completed course of training		85,000

of work only under sheltered conditions. The great majority of people on the Disabled Persons Register are working in open industry side by side with those who have no disability. This may in part be due to the "quota system," by which any employer of more than 20 workers must employ a "quota" of those who are registered as disabled; at present this quota is 3%. However, it is only fair to point out that many firms

employ more disabled men and women than they have to, while others are working with smaller firms or on their own account.

To supplement the quota scheme the Act also empowers the Minister to reserve certain jobs for the disabled, but so far the only jobs so designated are those of car-park attendant and electric-passenger-lift operator.

Finally, the Minister is empowered to provide sheltered work for those who are severely handicapped and unable to hold down jobs in open industry. In 1945 he set up a non-profit-making company—Remploy Limited—which now employs nearly 7,000 workers in 88 factories in different parts of the country. Other sheltered workshops employing some 6,000 people have been set up by voluntary organizations and local authorities and are largely financed by the Ministry of Labour.

Disablement Resettlement Officer

The disablement resettlement officer, commonly known as the D.R.O., is the key figure in placing disabled people in industry, and is specially trained for this resettlement work. There is at least one D.R.O. in each of the Ministry of Labour's 900 employment exchanges, and it is his job to advise disabled men and women on suitable work and help them to find it through his contacts with local employers. He may suggest a course at an industrial rehabilitation unit (I.R.U.) or vocational training at a Government training centre (G.T.C.) or elsewhere. He forms a vital link between medical and industrial rehabilitation. Patients are referred to him by hospital doctors, by family doctors, and sometimes by employers. He is guided by the doctor's recommendations and may attend hospital resettlement clinics. He also co-operates with voluntary organizations and local authority welfare services. Since 1944 over two million jobs have been found for disabled people in open industry through the D.R.O. service.

Industrial Rehabilitation Units

The first experimental I.R.U. was opened at Egham in 1943, and there are now 17 I.R.U.s situated in the main industrial areas (Fig. 1). Most of them are non-residential, although residential places are available at Egham, Leicester, and Granton for those people who cannot travel daily to their nearest unit. About 12,000 men and women pass through these units each year.

Many people attending I.R.U.s are sent, through the D.R.O. at their local employment exchange, on the recommendation of the family doctor or of the hospital doctor and medical social worker. The object of a course at the I.R.U. is to get a patient fit to work and accustomed to normal working conditions again. The I.R.U. is like a factory, and carries out production work under the supervision of skilled craftsmen. At the end of the course, which usually lasts about two months, the patient may be able to return to his previous job or similar work with another employer; he may need a lighter job or specialized training for a new trade. It is an essential part of industrial rehabilitation that the patient, or rehabilitee as he is now called, should be assessed and given expert vocational guidance. Each patient's course is planned individually at case conferences by an expert team, which includes the rehabilitation officer in

* Regional Medical Adviser, Ministry of Labour, London and South-eastern Region. Consultant in Physical Medicine, the Middlesex Hospital and Garston Manor Medical Rehabilitation Centre, Watford.

charge of the unit, its medical officer, an industrial psychologist, a social worker, the unit's own disablement resettlement officer, and the chief occupational supervisor, who is in charge of the workshops. A consultant psychiatrist is available to give specialist advice, and the unit doctor, who is often a local

trained at G.T.C.s, technical colleges, and residential colleges during the past 20 years exceeds 85,000 (see Table).

The role of the D.R.O. in organizing these services for the disabled is illustrated in Fig. 2.

I should mention here that the Minister of Labour has set up a National Advisory Council on the Employment of the Disabled with representatives from both sides of industry, from the medical profession, and from welfare organizations, and a country-wide network of nearly 300 disablement advisory committees, similarly constituted, which are attached to the main employment exchanges.

FIG. 1

general practitioner with industrial experience, is assisted by a nurse and by a remedial gymnast, who is in charge of a well-equipped gymnasium where hospital treatment can be continued. While at the I.R.U. each rehabilitee is paid tax-free maintenance allowances instead of National Health allowances.

Over 134,000 people have completed I.R.U. courses since 1944. A follow-up six months after rehabilitees have left the unit shows that generally between 60 and 70% are working or undergoing training. Between 15 and 20% of them are found suitable for vocational training.

Vocational Training

Some disabled persons require training in new trades, and for these the Ministry of Labour provides vocational training courses at one of its G.T.C.s, at technical or commercial colleges, or at one of the four residential centres run by voluntary organizations such as Queen Elizabeth's Training College, Leatherhead, or St. Lyses at Exeter.

Over 40 different trades are taught at G.T.C.s, where the disabled are trained side by side with other trainees. The selection of suitable candidates, the syllabus of training, and conditions of subsequent employment are arranged in consultation with representatives of both employers and of trade unions. Trainees are paid special allowances for themselves and their dependants while in training. Courses usually last from 6 to 12 months.

Arrangements for training are made through the D.R.O., and since 1944 over 50,000 disabled people have completed courses at G.T.C.s. The total number of disabled men and women

FIG. 2.—Organization method.

Discussion

I have summarized the main provisions of the 1944 Disabled Persons (Employment) Act and its effect on the resettlement of people in work. At first sight the statistics appear encouraging, but it would be wrong to assume that all is well and that nothing more need be done. Recruitment to I.R.U.s, for example, although variable, is disappointing in some areas. Too few orthopaedic cases are referred to them at present. When one remembers that some 70,000 motor-cyclists alone are injured on Britain's roads each year, many of them seriously, it is surprising that the I.R.U.s are not completely filled with road casualties, and this takes no account of the large number of industrial accidents. Yet, as Fletcher and Wheble (1964) have shown, excellent results in the rehabilitation of such patients can be achieved if there is close co-operation between orthopaedic surgeons, the D.R.O., and the medical officer at the I.R.U., with early transfer to an I.R.U.

One of the main problems is the physical separation of industrial and medical rehabilitation. The siting of the I.R.U. in an industrial area has certain advantages but may discourage those patients who find it difficult to travel by public transport, while liaison between unit officers and hospital staff is difficult if the

industrial estate is a long way from the hospital. Rehabilitation is not always a continuous process, as it should be, and in graduating from hospital to an I.R.U. the patient passes from the care of one team to another.

This problem was recognized by the Piercy Committee in 1956, for they recommended that two or three experimental comprehensive rehabilitation centres should be set up. Such a comprehensive centre would be associated with, and located as closely as possible to, a general hospital, and would provide within its boundaries a variety of services, including physiotherapy department, gymnasium, occupational therapy department, and industrial workshops provided by the Ministry of Labour. Specialist services would be readily available and staff would be shared with the hospital.

The Ad Hoc Committee on Rehabilitation set up by the Sheffield Regional Hospital Board (1962) was convinced that comprehensive rehabilitation units should be established in all major clinical areas to serve a minimum population of 250,000 and that I.R.U.s should be incorporated in such centres.

Experience of medical rehabilitation at Garston Manor Medical Rehabilitation Centre over the past nine years has convinced me of the need to transfer the patient progressively from

a medical programme to a work programme and thus expedite his return to work. This can best be achieved in a comprehensive rehabilitation centre. It is surely time that the experiment took place.

Summary

The provisions of the 1944 Disabled Persons (Employment) Act are summarized, and an attempt has been made to estimate their influence on the resettlement of disabled people in work during the past 20 years. There has been a steady expansion in the services provided by the Ministry of Labour. However, fuller use could be made of industrial rehabilitation units, and some of their disadvantages might be overcome by developing comprehensive rehabilitation centres.

REFERENCES

- Fletcher, G. C., and Wheble, V. H. (1964). *Brit. med. J.*, 1, 173.
Piercy, Lord (1956). Report of the Committee of Inquiry on the Rehabilitation, Training, and Resettlement of Disabled Persons. Ministry of Labour. H.M.S.O., Cmd. 9883.
Sheffield Regional Hospital Board (1962). Final Report of the Ad Hoc Committee on Rehabilitation.

Advertisement and Classification of Oral Contraceptives*

ARNOLD KLOPPER,† PH.D., M.D., F.R.C.O.G.

Brit. med. J., 1965, 2, 932-933

The use of oral contraceptives has increased very much since the first compound was marketed approximately 10 years ago. An inquiry to leading companies in this country and in the United States engaged in the trade produced estimates varying from 5 million to 20 million women all over the world taking these compounds daily. There is reason to believe that the number of users in Britain is not far short of half a million, and in view of the intensive advertising campaign conducted in Australia in recent years it would be surprising if they were far behind Britain in this respect. These observations need to be made for two reasons; first, to demonstrate how widespread their use is, and, secondly, to substantiate the claim that they represent a very considerable financial investment, and the commercial interests backing these drugs have at their disposal a formidable machine of medical persuasion. Any attempt to suggest a choice between trade preparations on the basis of their structure can have commercial results far larger than the available scientific facts would justify. It is not intended, therefore, that any preferences should be implied in classification, but merely to list and subdivide the compounds in common use in this country and to indicate in which respect their composition may be expected to influence their action.

The first fact which strikes one about the composition of all 11 oral contraceptives on the British market to-day (Table I) is that all are dispensed with an added oestrogen. It is a matter of common agreement that oestrogens will prevent ovulation by suppressing pituitary gonadotrophin secretion, and one of the likeliest theories of how oral contraceptives act is

that there is a synergism between the oestrogen and the gestagen, the former suppressing follicle-stimulating hormone (F.S.H.) and the latter luteinizing hormone (L.H.) secretion. This fits with the fact that women on oral contraceptives are, endocrinologically speaking, in a state of medical castration. They produce no endogenous ovarian hormones and give no evidence of the growth of Graafian follicles or corpora lutea. To impose a 28-day cycle on such women is evidence of our adherence to social and lunar convention, not a physiological necessity. In cases where ovulation is not suppressed it is likely that a contraceptive action is exerted at another level—for example, by preventing nidation of the fertilized ovum or by alteration of the cervical mucus.

TABLE I

Preparation	Oestrogen (mg.)	Progestogen (mg.)
Gynovlar	Ethinylloestradiol 0.05	Norethisterone acetate 3.0
Anovlar	" 0.05	" 4.0
Norlestrin	" 0.05	" 2.5
Volidan	" 0.05	Megestrol 4.0
Conovid	Mestranol 0.075	Norethynodrel 5.0
Conovid E	" 0.1	" 2.5
Previson	" 0.1	" 2.5
OrthoNovin	" 0.1	Norethisterone 2.0
Ovulen	" 0.1	Ethinodiol diacetate 1.0
Lyndiol	" 0.15	Lynestrenol 5.0
Feminor sequential	" 0.075	Norethynodrel 5.0

The advertisement campaigns by which these compounds are made known to the medical public have been designed with great care in order to direct thought along desired lines. For example, words like testosterone have an unfortunate connotation and are carefully avoided, although all but one of the compounds on the British market are 19-nortestosterone derivatives. It is important to the sale of these drugs that the

* Address given at the Annual Clinical Meeting of the British Medical Association, Dundee, 1965.

† Scientific Staff, Obstetric Medicine Research Unit (Medical Research Council), University of Aberdeen.