THE DISABLED PERSONS (EMPLOYMENT) ACT, 1944: SOME MEDICAL IMPLICATIONS*

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Historical Survey

It is only in very recent times that the problem of disablement has come to be accepted as a problem of employment, and that its range and complexity have been generally recognized. The Disabled Persons (Employment) Act dates from 1944, and the Ministry of Labour has been in the field of resettlement and rehabilitation only since 1941. It is equally true that industrial medicine is of comparatively recent growth. It might be worth while to glance at the reasons why that has been so, because I think in this case history does illumine the present.

It would probably be true of most of us that when we come to the problem of disablement for the first time we think of it in terms of a few unfortunate people who are only fit for specialized crafts such as basket-making and flower-making. Broadly, that was the only idea which prevailed up to the first world war. Between the wars a considerable development took place, especially on the medical side. Two factors were then operating to bring about a change. One was the fact of the war disabled which was brought home to all of us in that generation. The personal tragedy of blindness or amputation in an otherwise healthy young man appealed to public imagination in a way that the chronic case had never done, and one result of public concern for the disabled ex-serviceman was to stimulate progress in the treatment, both medical and social, of disablement generally.

The other factor was the growth of social legislation and in particular of workmen's compensation. That laid on industry the responsibility for its own casualties. The injured workman became a charge on production, and his early return to work therefore became important. It paid to restore him to full health at the earliest possible moment. One result of the measures that were taken originally for that purpose was to diminish the number of industrial casualties who were allowed to become permanently disabled.

But all that was still largely in the medical and social field. The recognition of the employment implications came in quite another way and only with the recent war. In 1941, to be exact, when the problem of finding manpower simultaneously for the Armed Forces and for industry became acute, we were obliged to look at the large number of men and women who might have substantial handicaps but nevertheless represented a potential labour force. So we launched a scheme to bring the disabled into the war effort. There may have been imagination in that, but there was primarily nothing of sentiment. And in operating that scheme we discovered, of course, a number of important things.

We discovered that the great majority of the disabled were capable, with proper selection of their job, of taking their place in ordinary employment alongside the able-bodied. We discovered that a great many of them could be placed in work without any training other than that on the job. Some might have to have the job broken down for them but, broadly speaking, given the selection of the worker for the job and job for the worker, the problem proved to be nothing like so formidable as had been thought. What is more, we found that, of those not able to take their place in ordinary competitive industry, most were capable of rendering some useful service under sheltered conditions and thus of contributing to national production.

Some Misapprehensions

It was in that way that the Ministry of Labour came into the field, and it was to conserve those lessons that the Disabled Persons (Employment) Act was framed. I emphasize this point and I have gone into the history in some detail in order to remove a number of misapprehensions.

One misapprehension is that the Ministry of Labour has somehow illicitly invaded the medical

* Statement made in opening a discussion at a meeting of the Birmingham Group of the Association of Industrial Medical Officers on Dec. 16, 1947, with Dr. Donald Stewart in the Chair.

field and is trying to do somebody else's job for them. Nothing is further from the truth. We are in this field for the reasons I have stated, with a limited interest and a specified commission, and we are much too busy with the parts of the job that are our proper responsibility to want to filch anyone else's job or infringe on their responsibility.

Another misapprehension is just the opposite. It is that because the Ministry of Labour is in the field then its contribution is the solution to everything. The Ministry of Labour has a contribution to make and it will gladly make it; but it is only one contribution among others. Advances in the employment aspects of the problem must be accompanied by similar advances in other fields, in medicine, in the hospital services and in the field of social legislation.

Still another misapprehension is to overlook the fact that the Ministry of Labour is in this field with a specifically industrial function, and to imagine that it ought necessarily to employ the same kind of person that is employed in hospital services on very much the same kind of work. Some people talk, for example, as if a Disablement Resettlement Officer (D.R.O.) ought to look like an unqualified medical practitioner and talk like a hospital almoner. The D.R.O. is there with quite a different function. He is there for his industrial knowledge because industry is a world of its own with its own technicalities and its own language, just as medicine is. A man is not a worse D.R.O. because he drops his "h's" or has not been through a university department of social science. The essential point is to see clearly and in their right perspective the distinctive contributions that each of us can make. Only by each contribution being fully made in its own field can the general advance we all want to see be achieved.

The Ministry of Labour's Commission

Let me now say something of what the Ministry of Labour's specific commission is. We have very definite statutory functions laid upon us by the Act.

1. We must maintain a register of persons who are handicapped by reason of their disability from getting or keeping work. That is the "Disabled Register."

2. We must from time to time prescribe a percentage proportion of disabled persons which all substantial employers of labour are required to employ. That is the "quota."

3. We must provide industrial rehabilitation and vocational training where these are required.

4. We must provide special facilities in the way of sheltered employment for those who are not able to work under ordinary conditions.

5. We must at all times use our best endeavours to find suitable work for the disabled by the best possible selection and placement methods. That is "selective placing."

Those are five apparently simple practical objectives, and you can understand why to the plain man they may seem a perfectly straightforward job requiring only common sense and human sympathy. But they are a great deal more complex than they look, and it is with these complications and elaborations that we are now concerned. Here are some of them.

Form D.P.1.—The form D.P.1 is the form on which the lay D.R.O. gets from the doctor medical evidence about the disability. This raises straight away the question of what medical evidence you need as a guide to placing a man in work. When we started we had a fairly simple form called R.D.1. That left the hospital or the doctor free to report the disability in their own terms and you can guess what happened then. The medical reports were expressed in medical terms which were difficult for a lay staff to understand. Similarly our lay staff, when they discussed cases with the medical man, were apt to refer to them in their technical terms (occupational terms, and so on) which the medical man did not always understand. It was like the tower of Babel: neither understood the other's language.

We therefore set up a small informal committee to solve the problem. It consisted of Mr. H. E. Griffiths, the London surgeon; Dr. E. L. Middleton, Medical Inspector of Factories; and Dr. R. H. Fleming, Director of Medical Services, Ministry of Pensions: and we associated with them some of our own experts in occupational classification who had drawn up the Schedule of Reserved Occupations. That small committee of doctors and industrial experts produced between them roughly the D.P.1 in its present form. The basic assumption underlying it is that what the lay placing officer needs is not the technicalities of diagnosis expressed in medical terms but the effects of the disability on functional capacity. He wants to have the ability or disability assessed in working terms; to be told what the man can do and what he cannot do. This the form does in terms of walking, standing, sitting, pushing, pulling, working on heights, working underground and so on, to meet the common hazards that are to be found in industrial occupations.

Despite its distinguished medical parentage the form met with a very mixed reception and it has never been possible to get it adopted for general use in the medical profession. For administrative and technical reasons, hospitals feel unable to complete

it, and it is not used to any great extent by the general medical practitioner. Those who do use the form tell us that it is quite simple to complete once you have done a full examination and diagnosis. But I must confess it is a somewhat formidable document. Nevertheless I think it is a pity it is not more generally used, because without something of the kind the placing officer has to carry on with what information he gets in whatever form he happens to get it.

We had thought that, if the D.P.1 proved to be a solution to the problem of medical evidence, we would use it as a basis on which to build up a series of variants to fit different classes of disability. We have, for example, produced a variant of the form for use in tuberculosis cases. But we have not carried differentiation any further, because really the form in which we get the medical evidence is not the crucial point. The right solution for our problem will depend, not upon any exchange of documents between us and the medical profession, but on the general relationship that exists between the medical world and the D.R.O. service. We require closer and better co-operation than can be obtained from any form of report, however good or however detailed, and we are trying to get that better and closer co-operation by another route.

Medical Interviewing Committees.—We are proposing to set up special Medical Interviewing Committees based on hospitals, to which we can refer individual cases of difficulty for special advice in connexion with placement. The first of these committees in this Region has been appointed at Stoke-on-Trent. Each of these committees will consist of a medical man from the hospital, of registrar status as a minimum, and a doctor with industrial experience. They will be able to call in specialist consultants if necessary. They can consult hospitals, private practitioners, industrial medical officers, or anybody else who may at any time previously have examined the man, and they will examine the man themselves. Then the D.R.O., who will be in attendance, can discuss the case with them and put to them any point of difficulty which arises from his point of view.

It is proposed that the Medical Interviewing Committee should start off by using the form D.P.1, but experience may very well show that a better form can be devised, and if it does then we shall not only have got our basic paper work done but we shall also have forged a valuable working link between the medical and industrial sides. The Medical Interviewing Committees and the D.R.O. by working closely together on actual cases will come to understand each other's problems. And

it really is vitally important that they should understand each other.

Links with Hospitals.—Our relationships in the Ministry with hospitals should be much closer than they are. The common explanation of why they are not as close as they might be is that our staff is not of the type who can meet doctors and almoners on equal terms. Well, suppose that is true. Where does it take us? Here is a tragic human problem—the problem of a sick man who has to find his way back to work. The key to his problem may lie partly in the medical field, but wherever the key lies it should be found. We owe it to the man himself, all of us, to put every bit of knowledge and effort at his disposal. Whether we are doctors, or D.R.O.'s, or almoners, or anybody else, every contribution that can be made to that man's problem should be made by all of us without prejudice and without standing upon the order of our going. What I would like to see is a perfectly normal two-way traffic between the hospitals and the D.R.O.'s, each relying on the other for what each can give, and neither expecting the other to be what they are not.

Industrial Rehabilitation.—The relationship between industrial rehabilitation and medical rehabilitation is a much-discussed question. The Act proceeds on the assumption that there are two distinct phases at which a person may need reconditioning and toning up. One embraces hospital treatment, the other the industrial process of putting a man in a job.

In the Ministry of Labour our normal contact with disabled people is neither in hospital nor immediately on discharge; and we find that there are substantial numbers of people among the ordinary clientele of the employment exchanges who, while not needing any obvious medical treatment, do need two things which closely resemble medical rehabilitation. One is a general toning up of the muscles and physique, and the other is a chance to try their capacities out on a range of industrial processes in order to discover what kind of employment is likely to suit them best. It was to give that class of person those two things that we set up our rehabilitation centre at Egham and are now proceeding to set up some twelve or fourteen additional centres, mainly non-residential.

The resemblance between industrial rehabilitation and medical rehabilitation has led to a good deal of confusion both in thinking and in practice. The history of what happened in practice is this: we had no intention of doing anything medical at Egham when we started, but we found that so many of those coming forward to Egham were really in need of medical treatment, such as physiotherapy

for example, that we had to instal considerable facilities of that kind. And that was not because D.R.O.'s were sending forward people whom they should have referred for medical rehabilitation locally.

According to the Ministry of Health, there are 520 general or special hospitals in England and Wales where the establishment of rehabilitation departments might reasonably be expected. In 1943 only 150 of the 520 had rehabilitation departments and, of the 150, 120 had only partial facilities, such as facilities for remedial exercises. In 1946, 333, or 64 per cent. of the 520, had rehabilitation departments, and of these 129 were partial. This means that even if we had wanted to refer people for medical rehabilitation there would in many cases have been nowhere to refer them. Therefore, once more, advances in our field must be accompanied by advances in the medical field, and vice versa.

We might, in practice, look at rehabilitation in three phases, each distinguishable at any rate by virtue of its immediate purpose.

1. The first is what I might call hospital rehabilitation, the purpose of which is to restore a man to full health and vigour. When I was young if one picked up pneumonia, for example, and went into hospital one was kept in bed six or seven weeks; then one crept around for ten days or a fortnight feeling like nothing on earth, and then was sent home. It is a very great gain that the hospital now has, as one of its objectives, the aim of carrying a man through to the point where he can go back to work, or at any rate is fit enough to face normal life again better, physically and mentally, than under the old regime.

2. Then at the other end is what you do in the more progressive industrial establishments. In some ways this is similar to what the good hospital does but it can be much more specific. It can do much more for the man because in your rehabilitation departments in factories you have a definite production line that you can work to in your treatment, and you have a natural range of jobs to which your rehabilitation can be directly related. In other words you can probably make a man not only fit for work but fit for a particular job.

3. Somewhere between those two comes the third type of rehabilitation that is required by my thesis. It is our special concern in the Ministry of Labour. The man as we pick him up is not in hospital; he may never have been in hospital; he is probably not in work and is probably not fit for full-time work. He may be just a problem case. He may have an employment disability rather than a physical disability; and what that man needs, as

far as we can see, is to have his problem assessed, to have the opportunity of adjusting himself to work, and to get some elementary training in the processes of work. That is, as I see it, the place and function of our industrial rehabilitation. It is post-hospital and it is general—as against the specific things you can do, for example at Austin's. In fact I am inclined to think that a great deal of it is training, and I am inclined to think too that when people talk about "training" for the disabled what they really have in mind is not training in the accepted industrial sense of training for a skilled craft but this elementary process that we call industrial rehabilitation.

There is a good deal of nonsense talked about training for industry. For 90 per cent. of jobs in industry a short period of training on the job itself is sufficient. For the remaining 10 per cent. a high degree of skill is needed which is normally acquired only after five years' apprenticeship. But if we are to train people to that degree of skill, we must be sure that they will gain entry to the industry and be accepted by the trade. This means that the numbers we train must be directly related to the numbers who can be so accepted and absorbed into employment on the completion of their training. So it is necessary to be extremely careful of talking in a general vague way of training for the disabled as if it were something that can be "laid on" for all and sundry regardless of what happens at the end of it.

Selective Placement.—The other main function of the Ministry is what I have called selective placing, i.e., the proper selection of jobs for workers and of workers for jobs. We can lay a statutory obligation on employers to employ a percentage of disabled people, but that takes us a very small distance unless everybody concerned (the employer, the works' doctor, the personnel manager, as well as the D.R.O.) is prepared to see that the disabled person is given an opportunity of using his talents to the best advantage.

To give that opportunity requires individual thought. One thing has become perfectly plain: although disabled people may be handicapped along one particular line, the great majority have capabilities that can be fruitfully used, given proper selection of the job for the worker and of the worker for the job. So first of all we want to know about these capabilities. To enable us to give suitable advice about what are the most appropriate jobs in any given case, it is necessary to have proper information about the remaining capacities of the disabled person. That we have tried to get, through the D.P.1; and we have now made arrangements to secure through the new Medical Interviewing

Committees that we get not only a written report analysing the functional capacities of the disabled person but also personal and oral advice about what type of work is thought to be most suitable for him.

But a detailed knowledge of the functional capacities is only one half the story; we need to know also the functional requirements of many thousands of particular jobs, and here there is a great gap in current knowledge. Neither the Ministry of Labour nor employers nor anyone else I know has any complete knowledge of what functional capacities are called for by particular jobs, though for certain jobs we have some detailed knowledge, and of others some very general information.

Need for Research

There is urgent need for further research and for much closer investigation into this matter of functional requirements of jobs than any official organization at any rate has so far been able to provide. Through a special working party at the Ministry of Labour, on which Dr. Stewart is the moving spirit, we are beginning to apply ourselves seriously to this. We are engaged at the present stage in trying to discover what has been done hitherto, and then to see if we can find a way forward. But of course it is an immense and highly technical subject. It is largely a matter for background research, and the research to be of value will have to correlate results in many different fields.

Job Analysis.—Job analysis, as it is called, is not merely a matter of job description. What is more, it is not a kind of trade in itself guaranteed to produce summarized data from which individuals can be unerringly allocated within the range of jobs

analysed. On the contrary job analysis seems to me of comparatively little practical use unless it is accompanied and directed by many kinds of information that you cannot get from a mere study of the mechanical operations. It is not enough, therefore, to prepare on the one hand a list of disabilities with their different functional assessments, and on the other a list of occupations with their different functional requirements, with a view to matching the two lists up automatically. Number 13 on the one list may not fit number 26 on the other, however much they look on paper as if they ought to fit. For one thing the two analyses would have to cover many scores of disabilities and many hundreds of different occupations; personal factors such as character, age, adaptability, previous experience, and personal interest, will prove to be just as important as the physical disability.

It may indeed well be that the practical value of job analysis is as a guide to training methods rather than as a guide to the solution of the problems of individual allocation to jobs; and for that kind of reason I am inclined to think that much of the work done in America on job analysis is much too facile and much too theoretical to be of practical use for general application. But we are not really entitled to say so unless or until we put the matter to some practical test ourselves. For such a test the Ministry of Labour could supply some part of the raw material, but it would not be competent to undertake the technical research. That would require some body like the Medical Research Council. Consequently, I hope, once we know what we want, to enlist the appropriate expert assistance, and, with the power and resources of a big Government department behind us, to get something really effective done.

DISCUSSION ON MR. TAYLOR'S PAPER

CHAIRMAN: There are two new and important developments that Mr. Taylor has told us about: the development of non-residential rehabilitation workshop centres; and the development of Medical Interviewing Committees on which will be a hospital registrar, an industrial medical officer, and the D.R.O. as secretary, together with outside consultants as required. Is this latter development being done in collaboration with the Ministry of Health?

MR. TAYLOR: Yes. The Ministry of Health is laying this service on for us, and we are guided by them on all matters of this kind—although the responsibility is ours of course for the use we make of their help.

DR. R. WRIGHT (Birmid Industries): Will the personnel on these Medical Interviewing Committees be appointed in a full-time capacity?

CHAIRMAN: Appointments are on a sessional basis, and are not whole-time appointments. The sessional fees have been agreed by the B.M.A. with the Ministry of Health.

DR. HEALEY: Have any general practitioners ever been asked to fill in D.P.1?

MR. TAYLOR: In respect of private patients, no; but as part-time doctors in the insurance medical service, yes.

There are two purposes for which we need medical evidence under the Act. One is when a man who is in employment comes along and says he is disabled and wants to be put on the register. If the disability is obvious, like the loss of a limb, we can register him straight away: if it is not so obvious we ask him to produce some medical evidence, and we give him a form

(D.P.32) to be filled in by his doctor. This merely certifies that he has a disability and indicates its nature. As this man is in work and is merely claiming the right to be registered it is for him to pay the fee. But if the certificate on D.P.32 is still not sufficient for our purpose we refer him to a doctor in the Insurance Medical Service for a report on D.P.1—and we pay for that.

The second purpose is for the unemployed man, where we need a detailed medical report about his disability for selective placing purposes. Here too we use the form D.P.1 through the Insurance Medical Service—and we pay the fee.

When the form was first devised it was hoped that the hospitals, and to some extent the medical profession, would use it quite generally, but for a number of reasons this has not been the case. Only the Ministry of Pensions and Service hospitals, some public hospitals, and a few hospitals with which we have special contacts, have ever used the form D.P.1 to any extent. The Ministry of Pensions' hospitals use it fully. A few general practitioners who are keen on functional analysis have also used it, but it has not been generally accepted by the medical profession.

DR. HEALEY: In our district of Stoke-on-Trent, so far as I know, only the Regional Medical Officers and the part-time Regional Medical Officers of the Ministry of Health have filled in form D.P.1. Can you say whether that filling in has been satisfactory or not?

MR. TAYLOR: Without a doubt, yes. We are perfectly satisfied with the results and we understand that the doctors who use it make no complaint about it.

DR. HEALEY: When you have a part-time Regional Medical Officer doing this work he is sent four or five people in a session of about two hours, and the fee for that is two guineas. But normally, in N.H.I. practice, the medical officer sees nine or ten cases. Why is this?

MR. TAYLOR: The fewer seen the better service, I expect. And the form does require some care and time to complete.

DR. HEALEY: It requires a full examination; then filling in the form is easy.

MR. TAYLOR: I agree. It is the examination that takes the time, not filling in the form. The hospital's difficulty is that, when the hospital takes in a man to operate on his arm, they have the man in for that specific purpose, and keep their record relevant to that purpose, but they do not, for example, test his eyesight. So when we ask for a D.P.1, which asks about this and many other questions, it means that the hospital has to undertake special examinations and write up the case from a different angle. These are real difficulties which I fully appreciate.

DR. HEALEY: In our hospital at Stoke we have nothing called a rehabilitation department, but we have a physiotherapy department, which I think is all you want. Perhaps it is only a matter of terminology.

MR. TAYLOR: Your hospital would come into the group which I described as having partial facilities for rehabilitation.

DR. HEALEY: I read an article in the *British Medical Journal* (1947, 2, 919) recently by an almoner who

criticised your training arrangements. You may get disabled workers trained, but are they going to be accepted by industry? In the case she cited it was finally decided that the man could do nothing but be a shoe repairer, and yet there were several quite hefty delays in the process of getting him a course of training. This man's only chance was to be a shoe repairer.

Arising out of this, what arrangements have you got with the Association of Master Shoe Repairers or the appropriate trades unions that they will accept up to 3 per cent. or in some cases say 10 or 30 per cent., of disabled workers?

MR. TAYLOR: We have agreements with all the trades unions and with employers as to the numbers which the particular craft can absorb. Within the limits of those numbers we can train men for the craft with the assurance that they will be accepted by the trade.

DR. HEALEY: They will not be cold-shouldered?

MR. TAYLOR: No, provided they come within the terms of the agreements. There is a limit to the number of people who can be admitted to any trade. It is perfectly true that training is a remedy for disability, because what better compensation can you give a man for a handicap than to give him a skill; but, against that, you have the practical difficulty that there is no point in training a man unless he will have an opportunity of earning his living in the trade for which you train him. I may say we have trained, since we started under this Act, some 25,000 disabled people, in the real sense of training for skilled crafts. So industry, of one kind or another, has actually taken on 25,000 disabled persons specifically trained by us.

DR. HEALEY: There are no untouchables?

MR. TAYLOR: No; not in the sense of refusal to countenance training.

CHAIRMAN: In the printing trade the minimum time of training, in any section, is apparently some years. I raised this point of taking on disabled men recently with a master printer. He described the difficulty he had with the unions on this matter of dilution with what they call "semi-skilled" dilutees. There was difficulty in getting disabled persons into this trade unless they were fully trained craftsmen.

MR. TAYLOR: There may be difficulty in some union branches. You make an agreement with headquarters and it does not always get down uniformly to every individual branch. But generally speaking the trades unions have been generous to us on admission of the disabled.

DR. HEALEY: The letter that came to the secretary of our hospital about Medical Interviewing Committees did not say anything about any member of the Committee being of "registrar" standard.

MR. TAYLOR: He has to be a person of some professional standing.

DR. W. T. BRUNYATE (Ministry of Health, Birmingham): As I understand the position, we want a man of the highest status who is prepared to give the time and effort wanted in this work. Stoke now has the first of these Committees to be set up in this Region and we have

been lucky to get men of the status of Mr. Zinck and Dr. Healey. We have not, of course, been able to give any ruling on how much time these posts are going to involve, nor do we know how frequently the committees will have to meet. My only doubt is whether Mr. Zinck and Dr. Healey will be able to give us as much time as will be required. I think it possible that they may find it necessary to put in an additional deputy who can spare more time than they are able to. For a start, however, we are fortunate to get these two men, one an honorary assistant surgeon and the other an honorary assistant physician on the staff of the main local hospital. We are hoping to appoint an industrial member to this Committee at an early date and then meetings will be able to begin.

CHAIRMAN : Could you tell us what type of person you hope to appoint as the industrial member.

DR. BRUNYATE : A man who has extensive experience of industrial medicine. The question arises again whether such a person will be able to give the amount of time involved. I have heard the suggestion that these committees may have to sit six sessions a week, and if the chairman has a deputy and the industrial member has a deputy that will mean they will each sit three times a week. Clearly a man who is a full-time industrial medical officer is not going to be able to give that amount of time. So whom shall we be able to find?

I had one other point. One of the things which Mr. Taylor only touched on is the training of the D.R.O.'s. I fully accept myself what Mr. Taylor said about what is required in a D.R.O. and that their training is a matter for the Ministry of Labour. D.R.O.'s who attend meetings will pick up valuable information about medical terminology which will enable them to appreciate what they get on the form. The proposition has been made that special training courses in hospitals lasting a fortnight or three weeks should be held at which D.R.O.'s should attend full-time with a view to obtaining a smattering of medical knowledge. We have not got any such courses established in this Region; and I personally doubt whether this kind of training would prove valuable to them in their work. I would very much like to know Mr. Taylor's views on this subject.

MR. TAYLOR : I am not really competent to express a view. There has been discussion on the point by the Medical Committee of the National Advisory Council* and the chairman is a member of that Committee. I should only embark on training of that kind to the extent and in the form recommended by the Medical Committee.

CHAIRMAN : There is a good deal of difference of opinion on the training of D.R.O.'s. Would Mr. Taylor care to elaborate the point?

MR. TAYLOR : Dr. F. S. Cooksey (Adviser on Physical Medicine to the Ministry of Health) produced at our request for this Medical Committee a programme and curriculum for a three weeks' course. There was a division of opinion among the medical men on the Committee and among the laymen who attend, as to how far you can either usefully or wisely go in trying to transmit a smattering of medical knowledge to the layman. Dr. Cooksey eventually agreed to see if he

could produce something simpler; and there the matter rests at the moment.

CHAIRMAN : The problem of training probably varies in different regions.

DR. W. J. LLOYD (Guest, Keen, and Nettlefolds) : On the question of training D.R.O.'s, there has been correspondence between Dr. Brunyate's department and the University as to the best course to lay down. After consideration we (the University Department of Social Medicine) put up a scheme to the Ministry of Labour that the best thing to do was to put the D.R.O.'s with an industrial medical officer for two or three weeks and let them have discussions about cases. We felt we could do a great deal to help in this way rather than by setting up a course.

A second point I wish to make is that the standard of treatment given in hospitals up and down the country is not as high as it should be. I am convinced that there are disabilities which should never arise and one of the chief drives should be to improve standards of treatment, and continuity of treatment right through. A man came to see me yesterday who had been burnt on the legs. After attending a certain hospital and after being skin-grafted he was sent home to live with another old man, having been given penicillin cream to dress his own wounds. The skin graft was broken down and all the money spent has been wasted just because the hospital doctor did not ask the district nurse to call.

Another point on the medical side is that we do want, if we can, to implement this Act better by the education of the medical student in its principles. When he starts clinical work in hospital wards the student is thirsty for the knife—I suppose we all were at that stage—and it is difficult to put over the social side to them. It is important to do this also even to senior members of teaching staffs at hospitals.

MR. TAYLOR : May I say one thing that comes to my mind arising from the early part of Dr. Lloyd's contribution. There are of course two types of training. We run training courses, within our own Department, for all the jobs done in the Ministry of Labour; that is, we run our own courses of lectures. That is ordinary departmental in-training. The course that we are talking about, however, is a higher type of thing altogether laid on from outside the Department. If this outside training is not feasible it does occur to me that those of you, particularly from the University, if you are willing to help, could do so if there is the kind of information that you can get across to the layman in an hour's lecture or a morning session at one of our in-training courses.

DR. LLOYD : This is really the same type of training as Dr. Cooksey suggested. It is so difficult to switch from one place to another and get coaching that the only thing is to get the D.R.O. to live with the industrial medical officer and at the end of a week discuss all the points and talk about the cases as they come along rather than by a lecture. I believe that in a large industrial establishment there is an abundance of clinical material. I do not think that a lecture set-up will produce very much at all.

MR. TAYLOR : We are faced with the problem of some method of getting our D.R.O.'s to understand your language and thought. And you see how the idea grows. Somebody or other advises us that the courses of in-training for D.R.O.'s do not give them any knowledge

* This committee consists of Sir Reginald Watson-Jones (Chairman), Professor T. Ferguson, Professor R. E. Lane, Dr. Maxwell Jones, and Dr. Donald Stewart.

about medicine, so what we ought to do is to give them three-week courses on medical matters. At Glasgow, Manchester, and London we tried that and there was division of opinion about it. We thought it was pretty good but the doctors did not. So then we said, let's try a more elementary kind of thing. But somebody says a little knowledge is worse than useless. So we still want the knowledge but we have not been able to find an acceptable way of getting it. There may in fact be no safe way of giving a layman just the right amount of medical knowledge.

DR. WRIGHT: It would be a good thing for industrial medical officers to invite D.R.O.'s to come and see them at their factories.

MR. TAYLOR: That would be excellent, especially in factories with rehabilitation departments.

CHAIRMAN: I think both Dr. Wright and Dr. Lloyd would agree that if the D.R.O.'s were to go to industrial medical officers it should be to those in firms with a positive and definite rehabilitation and resettlement policy.

MR. TAYLOR: I referred to rehabilitation departments because we are anxious to develop our own rehabilitation facilities. I should like to say that we are trying at the moment to lay on a non-residential industrial rehabilitation centre at Holyhead Road in Birmingham. The chairman has a close interest in this venture; would he care to say something about it?

CHAIRMAN: This new centre is evidently not to be confined to any one type of disability; and that difficult group of unemployables, creating a fascinating problem in resettlement, is to be catered for if at all possible. Final details are not yet available, but the factory, at Holyhead Road, from the point of view of factory premises, is first-class. It is now important that the Ministry of Labour should find the right manager and the right medical officer. Only thus can success be assured. Other officials suggested at the centre are a vocational guidance officer, a social welfare officer, a physical training instructor, and several occupational supervisors.

Places will be reserved for some 120 individuals, men and women. They will be recruited through hospitals, general practitioners, industrial medical officers, and Employment Exchanges. Arrangements have been made for physical toning-up, for example a gymnasium has been provided. In my view, however, the main way by which men can be reclaimed for industry is through work processes, if possible productive work. Men and women will be paid financial allowances on a fixed basis, probably that in force in Government Training Centres.* Hot mid-day meals would be provided five days a week, at a cost of 5s. per week.

It is essential that the medical profession in Birmingham should become well-informed on this new centre so that they can decide on the desirability, or otherwise, of referring patients to it. The Ministry of Labour

* Scale of weekly allowances (for persons over 20 years of age) paid at Government Training Centres.

	Men	Women
1. Persons without dependants	70s.	57s.
2. Persons with one or more dependants, children under 16, but no adult dependants	75s.	62s.
3. Persons with one adult dependant	80s.	67s.
4. Persons with one adult dependant and one or more dependant children	85s.	72s.

N.B.—These allowances are in no sense wages, and are not subject to deduction of income tax or National Insurance contributions.

appreciate this point and have agreed to prepare relevant literature for circulation to hospitals and doctors. It is possible that these new centres may become important training centres for D.R.O.'s and offer facilities for research.

DR. J. SQUIRE (Medical Research Council): I would like to underline Dr. Lloyd's point that hospital standards of treatment and rehabilitation are generally low. The other day I saw a man, employed in a saw mill, who had lost several fingers of his right hand. All the hospital had done was to let the hand heal; but surely plastic surgery would have been useful? I would like to feel that we recognize the fact that this man could still have had a lot done for him. Where an adequate rehabilitation department exists in a hospital it should be concerned with the job to which a man should return, and the maximum functional ability that can be obtained. A man with a broken leg who could do his job with a stiff leg might go back soon to work; but if there was a chance of giving him a mobile leg then he should be kept under treatment long enough irrespective of his work.

Mr. Taylor has said that 90 per cent. of jobs in industry do not require any training. I would like to qualify that by claiming that the standard of training on the job is at present very, very low, and that lack of training is responsible for much medical disability in the early months of employment. For example, many patients do not even know how to wash their hands, and after a time may get dermatitis out of ignorance. Perhaps the same problem arises when you take men out of rural jobs to city jobs or vice versa; training in how to look after themselves should be part of the training.

MR. TAYLOR: That kind of education would be part of our industrial rehabilitation schemes. On your first point, you are of course asking rather a lot of a layman to know whether a man can be medically made more of. I wonder how far a layman, taking over a disabled case from a medical authority, can do anything except assume that the medical authority has done its job?

DR. SQUIRE: Perhaps your new centres will be big enough to employ a medical officer, just as the industrial centres do, to watch over progress.

CHAIRMAN: It is proposed that each will have a part-time medical officer.

PROFESSOR T. MCKEOWN (Birmingham University): It is obvious that this problem of resettlement is very complex. Mr. Taylor touched on the question of analysis of the job and the need to know very much more about jobs. It seems to me that, where lay people are dealing with medical matters, there is always a danger of being too respectful of medical opinion. How far is the Ministry of Labour likely to interest itself also in the question of the medical side?

MR. TAYLOR: The answer lies in what I said to you about having to correlate results in a variety of fields. What we are proposing to do at the moment is to determine, as far as we can, the different kinds of research that we think are needed. Some of the factors lie in our field, others in the medical field, and some in the sociological field, but we hope eventually to persuade some really competent body like the Medical Research Council to undertake research into the whole of the factors. In other words the Ministry of Labour would not attempt to start research of this comprehensive character on its own.

PROFESSOR MCKEOWN : On this difficult question of the D.R.O. and his training I think anyone will agree that, faced with the practical problem of starting a new service, one has to do the best one can. Does Mr. Taylor think in the long view that the lay officer with only the knowledge or training he can get at the Ministry of Labour is likely to meet what are clearly very complex needs? You want to arrange something directed to purely practical needs. Universities have very fixed ideas of training in social science, medicine, etc., and do not respond always to needs in industry. But we now have a situation in which there is a need for a very important type of training. How far we carry the training depends upon the ultimate objective of the Ministry of Labour. The two-week training is very difficult; you cannot get anything useful in that time. But what kind of service are you aiming at? Is the present D.R.O. set-up the final pattern for industrial resettlement?

MR. TAYLOR : The answer is that there is nothing final about the present arrangements. We started, as you know, during the war at a time when manpower was at its lowest. We had parted, for example, with some 1,800 young men from the Employment Exchange service alone to the Forces. So, being faced with this new service, what did we do? We had a fair number of ex-servicemen from the 1914-18 war who would, at any rate, know what it was like to be disabled; and so we put that kind of person from our staff on to this work, but that did not mean they had any great knowledge. It was a stop-gap arrangement but sensible enough of its kind.

We have in the last two years taken into our service in the Ministry of Labour, through the Civil Service examination system, close on 4,000 young men of examination standard between the ages of 21 and 30, and I am told they are very good. We have still a further 2,000 to take in in the next eighteen months or so. So it can be seen that we are adding 6,000 men of good fresh blood to the Exchange Service. They will not all come on to the D.R.O. work at once of course, but you will agree that the situation promises well for the future.

But even with good young men we have still to solve the problem of how far the layman will ever be competent to perceive the full significance of medical considerations. And I just do not know the answer to that except that we are hoping to get some kind of help from the field of education, including the universities. We recently asked Mrs. Williams, Secretary of the Social Science Studies Board of London University, to do a special survey for us of how far specialized knowledge is relevant to our work and available. She has already produced a valuable report which we are in process of studying with her. I think that some fruitful ideas will come out of that, and we shall probably be approaching universities as to what there is in their teaching which is relevant to our work, and which can be transmitted to our staff by courses of training or further education.

PROFESSOR MCKEOWN : Can Mr. Taylor tell us if the Ministry have had any chance of assessing the results of the Act, such as a follow-up of cases from hospital sources, how long they remain in work, and how satisfactorily they are placed in work?

MR. TAYLOR : I do not think that we have anything you would call follow-up in the academic sense. What we do is to follow up in the popular sense at stated

intervals any cases that are not in touch with us. But of course that is not much use for research purposes or tabulated results. It is merely a practical method of checking whether the person is satisfactorily settled, and whether he needs any further help from us or not. We do, however, follow up especially those who have been through Egham.

MR. HALSTEAD (Psychiatric social worker, present as a guest) : The form D.P.1 does not seem to be well enough developed for psychiatric cases although at hospital we fill it up if asked. I thought that the Disabled Persons Register was going to be swollen to enormous proportions, but, as a member of a District Advisory Committee, I have been instrumental from time to time in turning down applicants who were in no sense psychiatric casualties.

I know a case of a man aged 25 just out of the army, who is too old for an apprenticeship. The trades unions will not accept him. Could Mr. Taylor comment on this?

MR. TAYLOR : If he is now 25 he should have started his apprenticeship before he went to the war. This type of case is frequently met with. A person goes to the war aged 18 and comes back 25, and then at that stage says, "If I had my time over again I would have been an engineer." But of course he should have thought of that at 16 when he was the right age.

CHAIRMAN : I believe that Mr. Halstead has drawn up a scheme on the supervision and resettlement of epileptics.

MR. TAYLOR : Have you seen the "epileptic" leaflet we have issued? We got Dr. Tyler Fox to describe the factors to be taken into consideration in employing epileptic sufferers; it is a leaflet we give to employers.

MR. HALSTEAD : We are collecting names and case-records of epileptics in Birmingham, and so far have upwards of 100, that is about a fifth of the population of epileptics in Birmingham. It is astonishing the number of jobs they are doing. We are ranging cases according to their disablement, and are wondering if the Ministry of Labour have any training they could have.

MR. TAYLOR : I would not like to express an opinion off-hand, but I would like to have that report. I may also mention that the Disabled Persons Employment Corporation are employing some epileptics at one of their Remploy factories. It is a small experiment and undoubtedly one of the things found is that the epileptic improves under work.

MR. H. S. GOSNEY (Midlands Regional Controller, Ministry of Labour) : I might usefully say a word on the question of D.R.O.'s, as the person responsible in this Region for their work. I take the view, having regard to the circumstances under which we started the scheme, that the D.R.O.'s are putting up a good show, but I should be the last to claim that we are satisfied with ourselves. The D.R.O.'s are doing a lot of good work in their own field and getting quite good marks from industry. But it is not the job of a D.R.O. to attempt to evaluate medical considerations or to pretend to be more than a specialized placing expert. It is not always realized that the industrial world has its own complexities and its own limiting factors. On the

question of follow-up, I suggest one has to be a little careful; for not everybody likes to be followed up. What is more, personal inquiries tend to be unsettling. There is a lot of restlessness about, and it will often happen that a person who is doing quite well in some job will give you fourteen reasons why he should leave it if you once unsettle him. We all tend to think there must be better jobs than the one we've got.

DR. A. A. WHITE (Austin Motor Company): There is a point in connexion with the training of D.R.O.'s which is of interest. These young people that you are bringing in, age 21 to 26, apparently members of the Civil Service, where are they going to get the industrial knowledge which you said was so important?

MR. TAYLOR: I said they would not necessarily be coming on to that particular type of work for some time. They will pick it up in the same way as Mr. Gosney and the others have done, by daily contact with industry.

DR. WHITE: What chance are they having to do this?

MR. GOSNEY: We have a highly-developed training

course for new entrants. They are taught the structure of industry and the meaning of occupational terms, and it is part of their training to visit factories. We have study-groups which take up industrial organization, industrial job analysis, and so on; these give the new entrant a good idea of local industry. The field is gradually widened from these beginnings.

MR. TAYLOR: The trouble is, of course, that one cannot get people into the Ministry who have served an apprenticeship in industry. But the Civil Service method of recruitment does by a mixture of examination and selection provide in normal times a good type of entrant who can be trained up to any pattern you want.

CHAIRMAN: Before closing there is one point I would like to mention. This meeting was called primarily to discuss methods whereby Ministry of Labour officials in this area could make closer and more effective contact with the medical profession. I think contacts have been initiated in a small way, by this meeting. But further liaison may be necessary and the Group Secretary, Dr. J. G. Billington, will, I know, be only too happy to make any further contacts or arrangements that the Ministry wish.