How do all the data on the presence of a circulating inhibitor of the sodium pump in essential hypertension fit in with the action of ANF,⁴⁴⁻⁵⁵ or are the two concepts independent? Is the low kallikrein excretion in patients with essential hypertension⁵⁶ and their normotensive children⁵⁷ a limiting factor in natriuresis, entailing an alternative natriuretic mechanism which is related to the hypertension? Undoubtedly there will be an enormous surge in physiological and clinical research and much work will have to be carried out before these interesting results are established on a scientific basis and the clinical questions can be answered.

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Unmet need in chronic disability

Have we one of the worst disability management services in Europe? The question was asked at the inaugural meeting of the Medical Disability Society, in a session entitled "The needs of those with multiple sclerosis are not met."

The fact that patients are still wrecked by deformity, said D L McLellan, is proof that needs are not met, for most contractures are unnecessary. He drew particular attention to a new method from Sweden for reducing spasticity by maintaining muscle stretch: if this is done for half an hour with the help of apparatus (and it could be done at home) the effect may last for several hours¹; the method may be better than the use of antispastic drugs. With further evaluation this might become a widespread technique, and perhaps remarkably it has hardly been tried so far in Britain. R C L Feneley, speaking about incontinence, referred to a series in which eight of the 16 patients with catheters had leaks and two others had appliances that leaked.² He believed that intermittent self catheterisation was a great advance that should be considered more often; and his conclusion was that since no doctor could know about all the possible continence devices there was a need for a continence adviser, possibly a nurse with comprehensive knowledge. In the prevention of pressure sores the needs of patients will not be met, suggested D Bader, until a physiological pressure monitor becomes available. A continuous tape recording device for attachment to wheelchairs is being developed at the Oxford Orthopaedic Engineering Centre, but meanwhile pressure on the buttocks may be reduced by using high density foam cushions of large surface area, with the surface scored. Considering the problems of mobility, J A A Hunter referred to his study of wheelchair users in south east Scotland, in which about half the patients with multiple sclerosis reported technical or design problems with their wheelchairs. Patients and also the medical profession, he concluded, need to have better information about what is available and be helped to make better use of it—an even more urgent task than improving what we have.

"If you have multiple sclerosis," someone said in the discussion, quoting a patient, "no one wants to know."

There is thus a great need for the model service outlined by R Langton Hewer. The ingredients are ordinary enough: making the diagnosis, and telling it, efficiently; effective help with common problems such as reduced mobility; better information for patients; and long term support, including immediate attention at times of deterioration and throughout the help of a "key worker"—who might be a social worker, trained briefly in the problems of managing disability, in close touch with both neurologist and general practitioner (or, as some said, the general practitioner himself).

Sufferers from multiple sclerosis are not, of course, the only ones who may lose out in the delivery of services. In any uncommon disabling disease there may be much the same deficiencies—inefficient help, with professionals and patients alike unaware of all that can be done and no one worker pulling everything together. Motor neurone disease provided further examples for the conference. Discreditable findings of a questionnaire survey were reported by Diana Staples: after nine months one woman, for instance, had not obtained the Possum environmental control system she needed or even received an assessment visit; while a man who was totally dependent on his wife belatedly read about mobility allowances and wondered whether he was eligible. A study on motor neurone disease was also reported by R Langton Hewer at the meeting of the Society for Research in Rehabilitation following that of the Medical Disability Society.³ Among 42 patients about half were supplied with aids too late in the course of their disease and many of these, especially wheelchairs and collars, were unsatisfactory; much distress, moreover, might have been relieved by aids, including an automatic turning bed, which was needed by at least a third of patients. The chief needs, he suggested, are immediate and informed support that anticipates complications, repeated assessments, efficient supply of aids, and one key worker. "Telephone clinics" and domiciliary visits by registrars as well as consultants were proposed as ways of improving medical contact.

Thus a recurring theme was the mismatch between what is known and available and what patients actually get. It is not just a question of more resources: present resources need to be used more effectively. This means both more efficiency and new ideas to make the most of what there is. In a session of the Medical Disability Society on the organisation of services the general opinion was that although everyone should practise rehabilitation there should be one person in each district to organise and coordinate resources—by analogy with marketing, a "product champion." According to one view, it does not matter what kind of professional this person is, provided that he or she has the energy and enthusiasm to fight for services, gather the necessary information, and promote education. But another view was that a consult-

ant with an overall interest in rehabilitation is needed to "fight tooth and nail through the tangles of bureaucracy to ensure services." The other crucial message to emerge concerned "consumer participation": not only more information but also more opportunities for independent living, which can be economical as well as being what many want. Disabled people should be helped to use services, as someone said, but often also in the long run should be helped to do without them—like a couple who against all the odds got married and moved into their own home, and with each other's help were able to manage without any services.

This clearly applies mainly to relatively young people. In geriatric units K Andrews, in a paper to the Society for Research in Rehabilitation, urged the use of nurses in rehabilitation, in the face of shortages of occupational therapists and physiotherapists: a diploma course in rehabilitation could train nurses for certain wards, who could then not only free some therapists for more specialised tasks but provide round the clock rehabilitation.

Against this background of unmet need, so much of it unnecessary, the Medical Disability Society* has been set up as a successor to the British Association for Rheumatology and Rehabilitation (sharing the latter's funds with the British Society for Rheumatology). But will it be able to do more than preach to the converted? The society's initial aim is to encourage the interest of doctors of every clinical specialty in the management of temporary and persisting disabilities. To do this it hopes to stimulate both undergraduate and postgraduate education in the management of acute and chronic disabling diseases, and all members have been asked to recruit interest and convene regional meetings related to rehabilitation and management of such disease. If the new society thus comes to act as a pressure group, hammering away at the message of how much more can be made available to disabled people, and is regarded as an authoritative source of advice and information on all matters connected with physical disability, inroads may be made into the deserts of unmet need.

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*Chairman Dr George Cochrane, Mary Marlborough Lodge, Nuffield Orthopaedic Centre, Oxford. Next meeting (the annual general meeting) 3 December 1984, on the theme "Present and future provision for the younger disabled," at the London Hospital; details from the honorary secretary, Dr Andrew Frank, Northwick Park Hospital, Harrow HA1 3UJ.

¹ Odéen I. Reduction of muscular hypertonus by long-term muscle stretch. *Scand J Rehab Med* 1981;13:93-9.

² Thomas TM, Karran OD, Meade TW. Management of urinary incontinence in patients with multiple sclerosis. *J R Coll Gen Pract* 1981;31:296-8.

³ Newrick PG, Langton Hewer R. Motor neurone disease: can we do better? *Br Med J* (in press).