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GENERAL PRACTITIONERS' ROLE IN SHAPING DISABLED WOMEN'S LIVES

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INTRODUCTION

Environment can be defined as embracing most aspects of the society people live in, such as physical features, political/economic structures and the social climate within which people function. Alternatively, the term environment may be used to identify particular features of the world, this is perhaps most commonly done when describing the physical composition of the world people live in. In order to explore the divide between illness and disability I will adopt a broad definition of environment, but primarily focus on the interaction between disabled women and GPs.

RELATIONSHIP BETWEEN MEDICINE AND THE ENVIRONMENT

Studies on women's health have revealed concerns about the social control aspects of medicine. Feminists have documented how the medical profession controls the lives of women and defines what is acceptable and unacceptable conduct. Helen Roberts explains:

‘... women and doctors (even if those doctors are women) don't just have subtly different viewpoints about health, they inhabit different worlds. Doctors have the power to define what is, and what is not, illness, what is and what is not appropriate behaviour in a patient; and what is to go on in the consulting room’ (Roberts, 1985, p. 2).

Feminists have argued that exploring the different ingredients that influence women's health is crucial to understanding sexist ideology. Notions of ‘normality’ and male superiority versus female inferiority are all based on theories and philosophies about the human body. Therefore examining the relationship between disabled women and GPs (General Practitioners or Family Doctors) is a useful mechanism for not only exploring the divide

between illness and disability, but also assessing how the medical world can determine the environment disabled women live in.

The medical model of disability which equates disability with illness, has been used extensively to organise and control the lives of disabled people. Focusing on an individualistic approach to disability, pathologising disabled people as problems, rather than recognising the structural oppression disabled people face, has blurred the distinction between illness and impairment. Consequently, on the one hand disabled people are having to challenge the relevance of a medical model of disability and advocate an understanding of disability based on attitudinal, environmental and institutional barriers; whilst on the other hand disabled people are also struggling to access appropriate health services.

In the past, disabled people have fought so hard to challenge the medicalisation of disability that anxieties about health needs have tended to be minimised. Concerns about the oppressive nature of medical treatment, and the fear of disability being construed as a catalogue of medical problems, has made disabled people wary of putting health issues on the public and/ or academic agenda. Whilst this may be an understandable response to the intrusive and often interventionist nature of the medical world there can be little doubt that disabled people, whether as a result of impairment, or as a consequence of everyday illnesses, are consumers of health services.

Margaret Lloyd (1992) points out:

‘.. the narrow defining of disability as clinical conditions results in an all-pervasiveness of doctors' power over disabled people's lives, of which the power to make decisions about fitness for work and entitlement to welfare benefits are but examples. This does not necessarily mean, however, that the medical aspects of their lives are unimportant for disabled people’ (p. 211).

The authority and control the medical profession exercises over the lives of disabled people, inevitably has a profound impact on both disabled men and disabled women. Nevertheless disabled people are not a homogenous group, factors such as race, class, age, sexuality, sex and gender also often play a significant role in shaping disabled people's experiences of health services. For example many Black disabled people have drawn attention to the way perceptions of people with Sickle Cell being ‘drug addicts’ often prevents access to health services. Similarly disabled women have raised concerns about the way rehabilitation programmes place an emphasis on ‘cultivating competitive attitudes’ and addressing concerns about male

sexuality, therefore whilst enabling men to aspire to dominant notions of masculinity, the needs of disabled women are ignored or left on the periphery (Morris 1989; Matthews, 1983).

Although the glory of the medical world does not shine in a local doctor's surgery, a GP can often act as the passport to a whole range of services and support. The response received by a GP significantly influences the lives of disabled women. GPs are not only the first point of contact when health matters need dealing with but they potentially exert a great deal of authority over other aspects of disabled women's lives. The medical model of disability means that GPs are often required to have an input on matters which many people would argue should not be in the domain of the medical profession.

In this paper, I will draw upon a small illustrative study of disabled women's experience of GP's, using qualitative material to suggest that the way GPs respond to the needs of disabled women can be disabling, and the division between illness and impairment is much more complex than both medical sociologists and disabled theorists have previously thought.

The paper will start by outlining the methodology and sample characteristics. Next it will discuss some of the reasons why disabled women have contact with GPs. It will then go on to highlight how GP's respond to disabled women's impairments and experience of illness. Finally the paper will conclude that whilst the relationship between illness and impairment is not as clear cut as we might like to think, care needs to be taken not to throw the baby out with the bath water.

RESEARCH METHODOLOGY

Initially, the research I aimed to carry out focused on in-depth interviews with a small number of women in order to establish the nature of disabled women's relationships with their general practitioners. Advertisements were placed in the disability press, inviting women to contact me if they were willing to take part in the study by completing a questionnaire or participating in a face-to-face interview. It was envisaged that a very short questionnaire with a series of open ended questions could be designed to obtain an idea of the types of issues that concerned disabled women. This would be followed with a small number of qualitative interviews.

The response to the advertisements was overwhelming. Over 100 women throughout the country responded and 3 organisations asked for multiple copies of the questionnaire. The telephone discussions and letters received

about the research clearly showed that disabled women's experience of GPs was a major area of concern for them.

In order to utilise the experience of all the women who expressed an interest in the research, a decision was made to develop the questionnaire further, so that it could be circulated to everyone, and to use it as a postal questionnaire. Women who could not fill in the questionnaire were offered the opportunity to take part in a telephone discussion, have a face-to-face interview or receive practical support to fill it in.

The questionnaire was designed to incorporate quantitative and qualitative information. Its primary aim was to explore the experiences of disabled women rather than investigate the characteristics of the GP or the GP's practice. It included open ended questions about current and previous GPs. A total of 80 completed questionnaires were returned by the deadline set.

LIMITATIONS OF THE RESEARCH

Most empirical research has its limitations; either because of the methodology used, or by the very nature of the subject matter itself, and sometimes a range of other unexpected factors. This research was no exception. Although it was not meant to be a representative study, the mere fact it relied on self selection built an inherent bias into the sample, as it inevitably attracted disabled women who wanted to share their experience of GPs. Also, relying on questionnaires as the main tool of the research excluded some disabled women, particularly women for whom written English is not their preferred method of communication. If this work is developed further it would be important to use, what Mike Oliver calls, an emancipatory research paradigm (Oliver, 1992) with a particular emphasis on group discussions and semi-structured interviews to target disabled women who are not properly represented at this stage.

The emphasis of the research was on setting an agenda from the perspective of disabled women, and there is therefore very little information about the women's GPs, the type of practice they work in, frequency of contact and so on. In retrospect it may have been useful to explore further information about the characteristics of GPs. Nevertheless the material elicited from the research provides a useful starting point for highlighting a neglected area of experiences.

Finally, the study does not incorporate any comparative work with non-disabled women or disabled men. It is clear that many of the issues raised

are not unique to disabled women. However the central thrust of this research is to demonstrate the extent to which GPs can shape the lives of disabled women, and to highlight the urgent need to include them in the discussions about women's health, primary health care and disabled people's use of health services.

CHARACTERISTICS OF THE SAMPLE

The women who responded were fairly well distributed geographically with 43% living in a city, 33% in a town and 20% in a village. Almost a third of the sample lived alone. Thirty percent lived with a partner, 14% with a partner and children, 7% lived with their children and another 7% lived with other family members. Only 1 person stated that she lived in a residential home so this is one group who are clearly under-represented in this study.

Only 4% of the sample did not identify their sexuality. The other 96% comprised 5% lesbians, 9% bi-sexual women and 82% heterosexual women. Given that it is estimated that 1 in 10 of the population are not heterosexual, the research appears to encompass a fairly representative proportion of lesbian and bi-sexual women.

Just over half (52%) of the women had children. This figure includes those whose children were grown up and had left home, as well as those whose children were still living with them.

African Caribbean women formed 5% of the sample, Asian women 2%, and UK European women 84%. It is difficult to know the proportion of Black disabled women in the population. Although their representation in this study may seem reasonable in theoretical terms, it has not ensured Black disabled women are a significant proportion of the sample.

Approximately two-thirds of the women were between the ages of 21 and 49 years, while only 14% were between the ages of 50 and 59 and another 14% over 60. The government's survey of disabled people indicated that the largest proportion of disabled women are over the age of 60 (OPCS, 1988). In contrast, this sample appears to mainly represent women whose impairments to a large extent are not part of the ageing process.

Twenty-nine percent of the women were born with an impairment, another 17% became disabled before the age of 22, while the remainder acquired their impairment later in adult life.

The majority of women described their impairment as a physical condition with multiple sclerosis accounting for 20%, back/ spinal injuries experienced by 12% and arthritis/ osteoarthritis by 11%. Deaf women only formed 3% of the sample and blind women totalled 5%, although 22% indicated that their impairment affected their sight.

DISABLED WOMEN'S CONTACT WITH GPs

Disabled women will present to their GPs for a whole host of reasons, ranging from a request for support with everyday illnesses such as flu, or gaining access to other health services, to obtaining specific advice around women's health issues like maternity services, or dealing with issues relating to their impairments.

In the research study the most common reason cited for contacting a GP was to obtain repeat prescriptions, or issues relating to one's impairments. A breakdown of the reasons why disabled women referred to their GPs showed that contact relating to women's health matters, such as screening services, menopause, children's health and contraception appeared to be relatively low, given that two thirds of the sample was between the ages of 21 and 49 years. On the other hand contact with a GP for medical reports and authorisation for other services appeared to be rather high. Whilst one may consider it appropriate for GPs to provide medical reports sometimes, concerns are inevitably raised about the excessive reliance on a medical model of disability which requires GPs to involve themselves in different spheres of disabled people' lives.

GPs are used extensively as the passport to other non-medical resources or activities. The pervasiveness of the medical model of disability is so extensive that access to employment, and leisure facilities can be dependent upon a GP's recommendation. The GP's response is often based on what s/he believes to be the ability and competence of the disabled person based on their functional impairment, rather than a recognition of how external factors, such as access to the right equipment, or how the availability of sign language interpreters at a work place, will effect them.

The personal views and prejudices of GPs play an important role in determining the type of support that will be provided to enable disabled people to live their lives. This is problematical as expectations of disabled people are often very low, as one disabled woman explains:

`previously I had a female GP, but she had a very naff attitude towards disability. Every visit for cold or flu I used to be told to stop working, I shouldn't bother to work due to my disability. Always assumed that I wouldn't be working at every visit, even though I had told her I work a number of times'.

Another woman talked about the difficulties she faced:

`It's like they fob me off because I am disabled ... They do not think I should have a life and being disabled expect to (be in) bed all time'.

Jenny talks about how her GP's opinion about women taking up benefits affected her Department of Social Security (DSS) application.

`She refused to give me a sick note, although when DSS phoned her she said I will never work, but she thought women who do not work should not get benefits. She even told DSS I did not need the benefit... I did not know if I should go without or maybe find another doctor'.

There may be specific values and beliefs held about certain groups of disabled women, like disabled lesbians, Black disabled women or women with learning difficulties. One woman with learning difficulties points out:

`GPs have the power to either allow people with learning difficulties to fully participate in society... My GP has abused his power. I had to stand up and advocate my ability to participate in student holidays, jobs and travel abroad. My GP was going to take my rights away from me because of his assumptions of people with learning difficulties'.

GPs shape the environment disabled women live in through their ability to enforce a medical model of disability. The individualistic approach to disability where substantial power is vested in GPs (and other health professionals) is a major source of contention for disabled people. The pervasiveness of the medical model of disability is a major barrier for disabled people. Maggie explains:

`I find difficult the extent to which my doctor is given control over my life. In the last year she has had to confirm that I can travel abroad, need the adaptations in my house, can have alcoholic drinks and give a full medical for a second mortgage... I have to pay for these services. She did not design the system and would like it to be different, nevertheless it does affect our relationship'.

Given that there are increasing demands upon GPs, and discussions about the most effective way of organising primary health care services are rife, this debate, exploring the divide between illness and disability, is very timely.

RELATIONSHIP BETWEEN ILLNESS AND IMPAIRMENT

It is not my intention to define illness, impairment and disability here as this has been done elsewhere in this volume (see chapter three). Nevertheless I will point out that the term impairment is used to describe a person's physical, emotional, sensory or learning difficulty condition, whereas illness refers to everyday ailments and other biological, physical, psychological issues that people would not define as 'normal' for them.

In the research study, disabled women described their general health as reasonably good, Lucy points out that 'having excellent general health, contact with GP is very limited'. But 8% of the women felt that their health was either fairly poor or very poor.

A common perception is one of disabled people being 'sick' or 'unwell'. Therefore it is quite possible that in an attempt to challenge popular beliefs (particularly within the medical profession) disabled women may have sub-consciously decided not to identify with the general ailments associated with everyday living. For example one woman explained that she 'refused to give in to illness'. The very fact she uses the term 'give in' suggests that illness is perceived as a weakness.

Some disabled women appear to be fighting the 'sick role' concept by asserting a positive identity and either managing everyday health concerns (like flu or stomach upsets) without going to a GP, or ignoring them until they become more serious.

'I am less affected by other illnesses and tend to ignore them which has led to the development of some serious illnesses due to neglect'.

Equally some disabled women were taking positive steps to ensure their general health was well maintained by taking vitamin tablets, changing their diet, trying to avoid stress and so on. On the whole disabled women were no more susceptible to illness than any other women.

For some disabled women illness and impairment were two totally separate issues, Victoria points out:

`... any illness I have is not related to my disability (referring to impairment)'.
`

Nevertheless for other disabled women the very nature of a woman's impairment or the practical affects of an illness can have other repercussions. More than half (58%) of the women felt that their impairment affected their experience of illness. Sometimes illness had very practical repercussions:

`Flu affects mobility including sitting down, turning in bed, getting into car, keeping comfortably warm. Coughs and colds affect ears and balance... Skin slower to heal with cuts'.

`My normal independence is very curtailed, I need to find a friend to make sure I have lots of drink and easy food, and try to get more "Care Hours" (external help) if I have a stomach bug'.

In other situations too, impairment and illness seemed to become inextricably linked.

`Vulnerable to infections, poor appetite and stomach problems. Also gynaecological problems'.

`Immunity system not so good, also monthly periods give rise to more arthritic pain, if coupled with a cold unable to do much'.

Wislocka explains how although her experience of illness is linked to her impairment sometimes, the perception at work is that the two things are synonymous with each other:

`I cannot keep fit and am more susceptible to flu, ear infections and chest infections.... but what is worse is that people at work do not see a difference between an impairment and illness, and perceive me as being "ill" and "weak" and taking a lot of time off work - whereas I have only had 14 days total sickness in 2 years'.

The relationship between illness and impairment is a complex one. On the one hand, impairments do not constitute a `medical problem' but are merely a fact of life that disabled women live with. On the other hand, some disabled women may be more vulnerable to illnesses because of an impairment, or the affects of an illness on an impairment.

Regardless of where disabled women's experience of impairment and/or illness falls in terms of a continuum of interaction between illness and impairment, there will be additional concerns arising from the specific health needs of disabled women as women. These can not be described as an illness or impairment, but are simply an integral part of women's health care needs. Again for some disabled women biological processes such as menstruation, child birth and menopause will not be affected by impairment, but for other disabled women the two may sometimes become linked. The challenge for GPs is whether they can manage the triangle of illness, impairment and women's health care needs.

GP's RESPONSE TO DISABLED WOMEN

The way GPs responded to disabled women's impairment varied greatly. Sally points out how her GP attributes any health problems to her impairment, she explains:

`Everything from sore throat to heavy periods is blamed on my "impairment".... he says you must expect these things in your circumstances'.

Sometimes the pure fact a disabled woman had an impairment was a source of curiosity and enthusiasm, particularly if it was something that the GP had not come across before in their everyday work. Several disabled women talked about how they had to deal with the GP's fascination with their impairment, when visiting for something else.

`They were usually more interested in my main impairment than the problem I was asking for help with, which some of the time had nothing to do with Muscular Dystrophy, i.e. it might have been a bump on the head or a rash'.

`My current GP is often more interested in my disability than in the reason for my visit. I have visited my GP for contraception only to be questioned about my lack of sight'.

For many disabled women the biggest problem they encountered was the reluctance of GPs to believe and support them in the diagnosis or treatment of their impairment.

`My current GP along with previous staff in the medical profession have insisted that my spinal problems are non-existent despite the findings

and opinions of chiropodist and others dealing with spinal difficulties. Current GP insists that my being overweight is the cause despite the fact that I had the same difficulty standing when I was four years of age and weighed two stone'.

Disabled women who were not believed or diagnosed inappropriately encountered substantial problems.

`I was told that my disability was psychosomatic and the GP refused to contact exam boards when I was in severe pain during one of my "A" level exams. The GP was paid for each appointment he attended, so I would miss endless classes to attend appointments. If I didn't turn up, the necessary painkillers and other medication was stopped and it was a major task to try and re-initiate them'.

Judith explains:

`Over-riding problem I have is I don't have my input recognised or believed... If I don't get well they say it's psychological (hypochondria etc.). If it's psychological it's not real/ "genuine" (apparently). If it's not real, it doesn't need treatment, it's a sign I just need to "pull myself together". If I argue/ disagree/ don't comply it's proof of these theories. It's a no-win situation regardless of whether it's physical or psychological. They know almost nothing about my situation and seem to feel that's my inadequacy!' .

The labelling of women's behaviour as psychosomatic, `neurotic', `hysterical' and so on was not an uncommon experience. This often led to a misunderstanding about disabled women's needs and inappropriate intervention.

`... she tried to get me admitted to the psychiatric hospital twice on the grounds that I was a hysteric/ suicide case. I was having an arthritis flare-up on both occasions...'

`As a child tinnitus and it's upsetting effects were ignored. I even had a spurious diagnosis of schizophrenia made due to the assumption that I was "backward" I would not know the difference between a noise or a voice in my ears'.

The experiences of women with learning difficulties and/or women with impairments which are not immediately physically visible, suggests that there are profound difficulties with the way GPs react. Women with learning

difficulties are rarely recognised as able to manage their affairs (with support of their choice), therefore GPs are more likely to accept the views and opinions of parents or other 'professionals'.

One disabled woman talked about how her GP refused to deal with her directly:

'Even though he knew I was going to university he still treated me like a child. Once when I was undressing prior to an examination I shouted answers over the screen to questions directed at my mother, which should have been directed at me. I was accused of being cheeky'.

GPs inability to tackle their own negative attitudes towards disabled people, can have massive repercussions for disabled people who have no alternative, but to rely on their GP for access to essential resources. Sally spoke of how difficult it was for her as a young disabled woman with her family doctor:

'I tried to cope secretly with incontinence - no support at all from GP. When I asked for (after support of other spinal cord injured women I met), told to obtain continence supplies "out of town" - to avoid bringing shame to family'.

Sometimes judgements about the nature of women's impairment influenced the way a GP responded. Alicia explains:

'My occupation of dancer/actress during my 20s/ early 30s caused many GPs to blame my profession for many movement problems, and my nomadic existence for my fluctuating menstrual cycle'.

The fact GPs can define women's experience, and behaviour in such judgmental terms, is indicative of the way the medical world has used sexist ideology to label and control women's behaviour.

Disabled women seemed to receive mixed messages about their roles as women. On the one hand disabled women's concerns have primarily been perceived in the context of their roles as 'baby making machines' and fulfilling their husbands needs:

'I realise that things are not always easy to diagnose but felt he was totally unco-operative. He suggested I see a psychologist (I refused). When my husband went to discuss with him how worried he was about

me, he asked him if he was more worried about his lack of sex life which was not the case'.

`The relief doctor came to see me and he got hold of my hand and my thumb and began twisting them, then said "oh it's rheumatics, have a baby every year, that will keep it at bay", it came back twice as bad as soon as I had the babies, but it is them that has kept me going all these years'.

On the other hand GPs were reluctant to acknowledge disabled women's need for health services specific to their requirements as women. Sharon had difficulty in getting her needs as a woman properly recognised. She explains:

`I feel that in general my GPs have viewed me firstly as a blind woman rather than a woman. This has meant that they have not given me the information I have often needed'.

She goes on to highlight the lengths her GP went to exert influence over what was `acceptable' or `unacceptable' for a disabled woman. The over-riding message being that a disabled women should not have children:

`When I was pregnant with my first son I received a letter from the hospital asking me to attend the out patients clinic. I had no idea what it was about, but assumed it was a check-up of some sort. When I arrived I was told that a letter had been sent by someone (whose name could not be divulged), who had suggested that I should be offered an abortion'.

Disabled women's right to have children has been attacked from many quarters. Feminist debates about genetic `engineering' or abortion have rarely taken on board the reality disabled women have to confront when the only option presented to them is sterilisation or abortion.

`GP refused to refer me to gynaecologist when I wanted to marry. Refused to prescribe the pill - advised me to obtain sterilisation privately - which I did - reluctantly. Feel very bitter as other women with my impairment have had support and encouragement to have children. Did not know I had the right to change doctor then or had any other choices'.

Sterilisation has been used extensively to control the sexual activities of women with learning difficulties. The emphasis with women with learning difficulties has predominately been on preventing reproduction rather than supporting women to make more informed decisions and choices about their

sex lives, this is probably as much a recognition of the fact women with learning difficulties are vulnerable to abuse, as it is a concern to control sexual behaviour, or prevent women with learning difficulties from having children.

Occasionally a GP was supportive in terms of enabling a disabled woman to choose whether or not to become a mother. Wislocka explains:

'Despite my back injury I am desperate to have a child. Everyone said I was crazy but my GP looked at it from both sides saying that there may be problems but if I was happy with being a mother I would feel less stressed and may feel less pain. She suggested a referral to someone who does couple counselling about fertility issues and also referred my husband for reversal of vasectomy'.

How a GP views and responds to a disabled woman's needs will not only have a crucial impact on the disabled woman's health care, but will have much wider ramifications for the way she is able to live her life.

GPs AND THE SOCIAL MODEL OF DISABILITY

A crucial question for GPs (and other health professionals) in responding to the needs of disabled women is whether or not the social model of disability is relevant to their work. Therefore it is useful to briefly explore what the social model may mean for GPs, other health professionals and even medical sociologists.

The social model of disability suggests that attitudinal, institutional and environmental barriers are the root cause of disabled people's oppression. Arguably the case is fairly clear cut, it is not people's impairments that exclude them from society, and render them subject to prejudice and discrimination, but rather the prevailing ideologies and structures within our society that prevents disabled people participating as full and equal members of society.

The common perception is that the social model of disability renders impairment redundant in any analysis of disability. Although the emphasis to date may have been on the structural barriers identified within a social model of disability, there is nothing to suggest that impairments are totally irrelevant. The social model of disability acknowledges impairment as one part of an equation, but accepted it as a given fact, just as the colour of a black person's skin in an analysis of racism. To counteract the heavy emphasis

given to impairment within the medical model of disability, in the past disabled people have focused attention away from impairment.

A GP who can recognise the importance of these structural factors shaping disabled women's lives is more likely to work in a way which empowers disabled women.

'My current GP has a number of spinal cord injured women in her practice, she is honest enough to admit we know more about our requirements than she does and if she can help us access other services she will do her best to do so'.

Another woman explained:

'On the positive side he has been interested in my purchase of a powered wheelchair seeing it (rightly) as an extension of my freedom and independence rather than as a symbol of having given up (the reaction of some of my friends)'.

As far as many disabled women are concerned a GP's ability to adopt a broader approach to their work and acknowledge how attitudinal, environmental and institutional barriers will effect them, does not negate the medical practitioner's role in managing their impairment, and general health needs, but rather enhances it.

A GP or any other person in the field of medicine who accepts and supports disabled women in tackling disabling barriers, and managing rather than 'curing' impairments will be much more effective in fulfilling their role and obligations within their profession. Judith speaks for a lot of disabled women when she says that what she wants most from her GP is to be listened to, have her experience and expertise acknowledged, and the GP's lack of experience and expertise acknowledged. Judith explains:

'I'm not asking for cure... I'm asking for support in managing my situation. This might mean acknowledging it's tough, helping me access resources, helping me plan health management and learn relevant skills'.

So where does that leave disabled theorists and medical sociologists?

CONCLUSION

I would like to suggest, as a conclusion to this debate, that the divide between illness and impairment is, perhaps, not as much of a massive gulf, as we may have thought before. Clearly, there are distinctions, depending on whether an individualistic or structural emphasis is adopted. However, there is also an awful lot of muddy marshland in between, where perhaps the distinctions are not quite as clear, and there may be scope for much more collaborative work between disabled people and those in the field of medicine.

This paper has highlighted how the medical world can control the environment disabled people live in, by drawing specific attention to the way GPs respond to the needs of disabled women. It has also demonstrated that the relationship between disabled women's experience of illness, impairment and health needs as women is sometimes totally separate, and at other times intricately woven with each other. Therefore whilst there is a lot of concern about the pervasiveness of the medical model, there is a clear need for people in the field of medicine to work with disabled people to enable them to manage their impairments and illnesses in a way which is defined as being appropriate by the disabled person.

Finally the social model of disability is not irrelevant to GPs, medical practitioners and academics, as it provides a framework for recognising both individual factors (that is impairment) and external barriers. The challenge now is for disabled people and medical sociologists to work together to find out how we can wade through the muddy marshland, without having to throw out the important work that has been done to reach an understanding of illness and disability.

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