REHABILITATION AND PHYSICAL MEDICINE

A Survey of the Services Provided in the United Kingdom by the National Health Service

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THE impairment of the capacity for life and work, by injury or disease or congenital abnormality, is one of the world's great personal and social afflictions. Yet the medical profession has been slow to accept the vital role of rehabilitation in completing the treatment and care of the patient. Many clinicians feel that their responsibility ends when the medical treatment of the acute phase is over. Surely the only true criterion of recovery is the restoration of the capacity for work—covering both capacity for gainful employment and for recreational activities. In paragraph 42 of the report of the Piercy committee it is stated that " consultants and general practitioners are still slow to consider the rehabilitation needs of their patients, and doctors still need further education in the scope and nature and potentialities of rehabilitation ". The Piercy committee " trusts that all possible steps will be taken by medical schools, and by the medical profession generally, to bring home to doctors their responsibility for leadership in this field ". It is difficult to obtain accurate figures of the number of disabled in our population, this being mainly due to difficulty of definition of disablement, and the varying differences in the standards of normality. Some with apparently slight disability are totally unable to work, and are therefore severely disabled; whilst others with what would appear to be severe physical defects manage to perform a full gainful day's work in open or sheltered employment, and do not consider themselves to be disabled. It is estimated that in most western countries at least ten per cent, and possibly nearer 15 per cent, of the population needs some special care or help because they are disabled either mentally or physically. In 1963 an Upjohn Travelling Fellowship enabled me to visit many areas and look at the rehabilitation services. It soon became apparent that these varied greatly from place to place; in some areas the regional hospital boards seemed to be ' rehabilitation-minded ' and provided a very full and comprehensive service. In other areas the regional hospital boards had done virtually nothing

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and any services that existed were provided by voluntary bodies. " Rehabilitation should relate to the whole man, and not merely to his disease, and yet in this phase of the illness the patient is left to fend for himself more than in any other." (Porritt Report, para. 510.) It is just over eight years since the Committee of Inquiry on the Rehabilitation, Training and Resettlement of Disabled Persons reported. What has been done to implement this report? The answer must be, very little. The report of the Medical Services Review Committee expressed very definite views concerning the scope of the rehabilitation services, and stated in paragraph 510 " organized rehabilitation is largely non-existent."

I wrote to every regional hospital board in the United Kingdom and asked them to give me a brief report on the rehabilitation and physical medicine services that they provided. To ensure some uniformity of the replies, and to enable me to compare these services throughout the country, I asked seven specific questions:

(1) Is there a consultant in physical medicine in your region who is responsible for rehabilitation services?
(2) If so, is he full-time employed on these duties, or does he have another appointment, e.g. in rheumatology, neurology, orthopaedic surgery, etc.?
(3) Is there a medical rehabilitation centre or a department of physical medicine under his care?
(4) If so, is it part of a general hospital or is it a separate unit?
(5) Do you have any specialist rehabilitation units for chronic sick, e.g. paraplegics, spastics, epileptics, etc.?
(6) If so are they entirely financed by the regional hospital board, or are they partly financed by voluntary effort?
(7) Any other comments that you might care to make, especially in regard to future plans for expansion of the services.

The response to my letter was remarkable, and the senior administrative medical officers of the regional hospital boards gave me full details of the services provided in their regions. All of the 21 regional hospital boards in England, Wales, Scotland and Northern Ireland replied and a comprehensive picture of the whole country was obtained. The wide variance in rehabilitation services was confirmed. The replies varied from " in this region there are no consultants in physical medicine. We had one . . . many years ago, but when he left it was decided not to make a replacement," to " we have in this region 22 consultants in physical medicine," and later in their reply this region states " we are not wholly satisfied with the present organization of the rehabilitation services."

From table I, it will be seen that out of the 21 hospital regions in the United Kingdom, 16 have consultants in physical medicine, and in all but one of these regions the consultants are full-time or maximum part-time in their speciality. A number of regions employ

TABLE I

SUMMARY OF ANSWERS TO QUESTIONS 1 AND 2

Regional hospital boards	*England and Wales*		*Scotland*		*N. Ireland*		*All regions*	
	Yes	*No*	*Yes*	*No*	*Yes*	*No*	*Yes*	*No*
(1) Is there a consultant in physical medicine in your region?	12	3	3	2	1	0	16	5
	Full time	*Part time*	*Full time*	*Part time*	*Full time*	*Part time*	*Full time*	*Part time*
(2) Is he employed full or part time?	12	0	2	1	0	1	14	2

N.B.—These figures refer to the regions employing consultants in physical medicine and not to the number of consultants employed. (See table II).

TABLE II

GEOGRAPHICAL DISTRIBUTION OF CONSULTANTS IN PHYSICAL MEDICINE

Regions	*S.E.*	*S.W.*	*N.E.*	*N.W.*	*Total*
London Metropolitan Boards	15	10	17	22	64
Other English Boards..	1	16	6	1	24
Scotland	0	1	2	0	3
Wales	2 In whole country				2
Northern Ireland ..	1 In whole country				1
Total for the United Kingdom ..					94

In order to make the above figures comparable the areas in the table do not correspond to the Regional Hospital Board areas in every case.

both whole-time and part-time consultants, the part-time consultants usually being rheumatologists, orthopaedic surgeons or neurologists, in that order. At first sight the fact that 16 regions had already established consultants in physical medicine seemed fairly satisfactory. But the geographical breakdown was not so good. Of the total 94 whole-time and part-time consultants, 64 are employed in the London metropolitan regions, and 24 are spread out through the rest of England. Wales has two, Scotland three, and Northern Ireland one. The number of physical medicine specialists per region also varies considerably. Eleven regions employ between one and five consultants, one being the commonest number. Two regions employ between six and ten consultants, and as was expected, the London regions employed the largest number of consultants; the north-west metropolitan region has 22 consultants, the north-east has 17, the south-east has 15 and the south-west ten. All regions except three in England and Wales had departments of physical medicine, under the care of a physical medicine specialist, either as part of a general hospital or as a separate unit, for example, the Camden Road Medical Rehabilitation Centre in London or the residential type like Garston Manor in Watford. Three of the five Scottish regions have departments of physical medicine under consultant supervision; two units are part of general hospitals, and one is a separate entity. In Northern Ireland there is a department of physical medicine attached to the main teaching hospital in Belfast. One English region has a completely separate rehabilitation unit which is not under the charge of a consultant in physical medicine. Two-thirds of all the regions had plans to extend their rehabilitation services, and I will deal with this later.

Not quite so satisfactory, however, is the number of specialist rehabilitation units for such cases as paraplegics, spinal injuries, spastics, epileptics, young chronic sick and geriatrics, and this finding is in keeping with that of the Porritt report: " clearly there wonld have to be special residential units for the rehabilitation of, for example, paraplegics, deaf and dumb, blind, spastics and the victims of polio. Such units already exist, but many more are needed." (para. 514). The following figures were obtained from replies to question 5 of my letter, and deal mainly with the units financed and run by regional hospital boards. A large number of voluntarily sponsored units do exist in all areas, but only a few of these were referred to by the senior administrative medical officers in their replies. Most of the special units and schools for spastics are financed and run by the National Spastics Society in England and Wales, and the Scottish Council for the Care of Spastics in Scotland, although six regional boards in England did have specialist units attached to hospitals for the care and assessment of spastics. Paraplegics and spinal injuries are catered for in six units in England and

Wales, and one at Edenhall in Scotland. The care and rehabilitation of the epileptic is also a divided responsibility, part voluntary and part from public funds. Many epileptics are accommodated in neurological units of general hospitals, and in the mental hospitals. But in the whole of England there are only four units for epileptics run entirely as a regional board commitment. Wales has no specialist units for epileptics, but these patients are stated to be admitted to beds in general hospitals as required and fortnightly and monthly clinics are held in two general hospitals in Wales to supervise the after-care of the epileptic. Five regional hospital boards in England make provision for young chronic sick, but none do in Scotland, Wales or Northern Ireland. Many of the young chronic sick are looked after in homes financed by voluntary contribution or local authority, and the Ministry of Labour also makes grants towards the training of these people at residential colleges. The best-known of the sheltered workshops is Remploy Limited. This is a non-profit-making limited company which runs over 90 factories in the United Kingdom, making goods of all descriptions which are sold in the open market. Remploy makes a loss of about two million pounds per annum, and this is made up from public funds. In a small way it also organizes homework for the more severely disabled. The disabled work a 40 hour week and are paid normal union rates. There are several village settlements in England where the chronic sick live and work as a community. Examples of these are the Enham Alamein village centre in Hampshire, and the Papworth village settlement. In Surrey, Dorincourt Estates provides living accommodation and sheltered workshops for the most severely disabled, one of their best-known products being decorative tiles. The financial structure of these residential sheltered workshops is rather complicated, their income coming from the sale of goods, from voluntary contributions, and from local authorities in the areas from which the disabled originally come; the Ministry of Labour also makes training grants under certain circumstances; the medical care of these persons is a commitment under the National Health Service. Recent years have seen a rapid expansion in the development of the geriatric services, and most regions now have a fairly well-developed service, although the number of beds is as yet generally inadequate.

It is important not to think of rehabilitation as being concerned only with the man's return to gainful employment, at an earlier stage its aims should be to teach the patient to live an independent existence again. It is said that those engaged in domestic household duties form the largest single working group in the country, but it is only in recent years that rehabilitation units have come to recognize this. Now fortunately, a number of them have either kitchens or

complete flats where aids to daily living are demonstrated, and skill in using them acquired. A good example of this is the department at the Royal Hampshire County Hospital in Winchester, where Dr Russell Grant has designed kitchens and flats where severely disabled patients live and look after themselves, doing their own cooking, washing and housework. Here there is even a mobile kitchen so that a patient completely confined to bed can still prepare a meal. The transitional step between medical and industrial rehabilitation is made in some units where actual work conditions are imitated. Edinburgh's Astley Ainslie Hospital has a model section of a coal face which allows mine workers to have a chance to try out their limbs and backs in something approximating to working conditions. Also at this hospital, the rear section of a double-decker bus allows patients to accustom themselves to mounting and dismounting from public transport. The final stage in the rehabilitation programme is largely the responsibility of the Ministry of Labour, and this is carried out in their Industrial Rehabilitation Units and Government Training Centres. In the I.R.U. men and women are assessed and either toned up to return to their former occupation or guided into some other suitable work. A number will be found suitable for vocational training in a new trade. and will then go on to a government training centre, or a residential training college.

I have already stated that two-thirds of hospital boards realize the need to expand and improve their rehabilitation services, and they have set up committees to look into the matter from a local point of view, and to make recommendations. The Scottish Western region, for instance, has conducted such a survey and is at present analysing its results. Already under way in that region is a most interesting project at Belvedere Hospital in Glasgow; here it is hoped to have a combined medical and industrial rehabilitation unit, under a unified administration. This is being financed in part by the hospital board, and in part by the Ministry of Labour, and there should be complete continuity in the process of rehabilitation. Scotland's south-eastern region plans to develop the Astley Ainslie Hospital as a centre for co-ordinated regional rehabilitation services. The other three Scottish regions all state that they have plans to set up rehabilitation centres in their hospital development programmes. The Northern Ireland hospital authority and five English regions all stated that definite plans for expansion were in progress. Newcastle's adviser in physical medicine has drawn up an excellent report which has been accepted by the regional board as the basis for further development of rehabilitation services. Sheffield has an active rehabilitation committee which was set up following the recommendations of the Piercy report; this committee has in turn produced a full report with recommendations referring to the Sheffield region.

Discussion

It will be seen from the above brief survey that there has been some awakening of interest in rehabilitation and physical medicine. Not so many years ago, physical medicine was an esoteric term (even yet some doctors might have difficulty in defining exactly what it means) but it is encouraging that today four out of five of all regional hospital boards have now got specialist units in this field. Along with physical medicine, rehabilitation has also progressed. Not all regions, however, were entirely in agreement with the setting up of rehabilitation units, and two regions stated emphatically that they considered that rehabilitation was part of the function of every clinician and should not be thought of as a specialized activity. One regional hospital board stated that it was not its policy to appoint a consultant in physical medicine " rather do we preach that each and every consultant should be responsible for the rehabilitation of his own patients. It is, we think, the failure of this policy which has allowed departments of physical medicine to appear." These opinions certainly do have more than a grain of truth in them, and in the setting up of departments of physical medicine and rehabilitation one must strive to see that they are closely integrated with all other hospital departments. One would never suggest that rehabilitation should be a specialized activity to be undertaken when the clinicians' responsibility has come to an end; it is an integral part of treatment from the very beginning of the illness. The aim of good medical practice is to restore the patient as near to full health and happiness as possible, and this cannot be achieved unless the patient can once again fit into his family and work environment. It is perhaps an exaggeration to say that rehabilitation should begin while the patient is in the ambulance on his way into hospital, but it does serve to stress the point that rehabilitation should be commenced as early as possible. This is also clearly stated in the evidence given by the British Association of Physical Medicine to the Piercy committee,

> ...from the very earliest days of the illness, consideration should be given to the probable outcome; and whenever possible, the patient and his family should be given an estimate of his prospects. The doctor should try to plant in his mind as soon as may be appropriate the idea of an early return to work and normal life, or as near to normal life as possible, and this must be maintained and strengthened by every member of the team during the process of rehabilitation.

As regards the regional hospital board whose policy was not to appoint a consultant in physical medicine, it no doubt has consultants in other branches of medicine, such as dermatology, chest diseases, geriatrics and it would not expect the general physician to cope with all these specialities. Yet apparently they expect all their consultants also to have specialist knowledge in the field of physical medicine and rehabilitation.

The consultant in physical medicine and rehabilitation has to have a sound knowledge of internal medicine and an expert knowledge of his own subject, including physiotherapy, occupational therapy, and remedial exercises. He has to have a thorough knowledge of local industry and working conditions, and the physical and mental demands that local industry makes on its workers. He has to take a broad, long-term view not only of the patient as a whole but also as a person in relation to his home and work environment. He has to bear in mind the man's domestic and financial responsibilities, and if the patient is unable to fit again into his previous work environment, he has to advise and help him to modify this to his needs and capabilities. The policy, therefore, not to appoint a consultant in physical medicine is a retrograde step not in keeping with modern thought: " we consider that there is a need for well-trained consultants in rehabilitation to act as co-ordinators of all forms of treatment in this phase." (Porritt report, para. 512). The British Medical Association has stressed that " only a person who is medically trained can advise a patient with a full understanding of his disability . . . there must, therefore, be continuous medical supervision of the patient throughout the process of rehabilitation ".

Summary

Because it was felt that rehabilitation facilities offered by the regional hospital boards varied greatly throughout the United Kingdom, and in an attempt to find out how the Piercy report had been implemented now eight years after it was placed before Parliament, the author of this article wrote to all regional hospital boards in the United Kingdom, and their replies are discussed. The situation is perhaps slightly better than the author anticipated in that three-quarters of all regions had consultants in physical medicine and departments dealing with this and rehabilitation. Two thirds of regions have definite plans to extend the physical medicine and rehabilitation services. The number of specialist rehabilitation units dealing with epileptics, spastics, paraplegics and chronic sick, is not so satisfactory as regards the National Health Service commitments, and much of the work at present is being carried out by voluntary organizations. Sheltered workshops and village settlement communities for the young and the chronic sick are mentioned, but the majority of these have no connection with the hospital service. The opinion that rehabilitation is part of the duty and function of every clinician and not a specialized activity is put forward and discussed. It is agreed that every clinician should have rehabilitation in mind from the very earliest days of his patient's illness or injury, and that rehabilitation should be a continuous part of medical care and treatment. It is essential that planned co-ordinated use of physiotherapy, remedial exercises and occupational therapy should

be made under the supervision and guidance of a medically qualified person who has a sound knowledge of internal medicine and a specialized knowledge of these medical auxiliaries, and of local industrial conditions; a doctor who will take a broad long-term view of the patient as a whole and also in relation to his home, family and work environment. It is encouraging to note that there is a definite awakening of interest throughout the country in the problems of physical medicine and rehabilitation.

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Studies on killed and attenuated measles vaccines in general practice. G. I. WATSON. *Brit. med. J.* 1965. **2**, 13.

Measles vaccines, either killed or attenuated live vaccines, were given to 69 children and three adults and the clinical and serological reactions recorded. Adverse clinical reactions to live vaccines appeared maximal in children aged three to six years but these reactions were obviated by giving a dose of killed vaccine three or more weeks before the live vaccine.

Rapid immunization of measles contacts with live attenuated vaccines was possible up to the third evening after contact with symptoms in the primary case.