Occupational therapy

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I should like to discuss some of the ways in which occupational therapists can sometimes help to solve the problems of the person disabled by rheumatoid arthritis. When considering the problems of the disabled living within the community, the problems of the person with rheumatoid arthritis immediately spring to mind. There is severe limitation of movement and resulting restriction of activity. In these days, however, many people no longer look forward to years of chronic invalidism and dependence upon others. With the help and advances in medical knowledge and treatment, sufferers from rheumatoid arthritis now have the right to expect help and guidance to enable them to make the best possible use of their remaining abilities, and to be able to take their rightful place in society. This help and guidance for both patient and relatives is often to be found in the physical medicine department of the local hospital; the physiotherapist, occupational therapist and medical social worker, under the direction of the rheumatologist and the consultant in physical medicine, work closely together as a team to provide a comprehensive treatment plan for the individual. As an accepted member of this team the occupational therapist has her part to play in the overall treatment plan. Over the past ten years the occupational therapist has changed her rôle; no longer is she expected simply to provide occupation or diversion. Occupation is still a valuable part of treatment, but only if it is purposeful and therapeutic. As a matter of routine in many hospitals today, the occupational therapist and physiotherapist together with the medical social worker carry out regular assessments of their patients' activities, and frequently these are followed by visits to the patients' own home. At Mount Vernon Hospital the 'activity of daily living' assessments are carried out jointly by the occupational therapist and physiotherapist who are treating the patient. The assessment room is not as grand as the name implies, in fact it is a partitioned-off part of the gymnasium and occupational therapy departments; with the aid of simple equipment it is easy to discover the patient's functional difficulties.

The room contains a hand basin, lavatory and bath, and these items are all movable with the exception of the bath, so that they can be rearranged to make it as much like the patient's home surroundings as possible. An ordinary hospital bed has been cut down to make it the height of a divan, and blocks under the bed make it adjustable to give the height that may be necessary. A wooden commode and a chair are also used in assessment. The results of these assessments show clearly the degree of physical disablement. They also enable the therapists to become more closely acquainted with the patient, and thus know more exactly their reaction and adjustment to their disability. Home visits, as well as providing the opportunity for the staff and patients to study the home situation, enable the therapist to meet other members of the family and to see the problems from yet one more angle. With the results of these broadly-based assessments and perhaps more detailed social reports from the medical social worker, and the hope of the fullest possible co-operation from the patient, the consultant is able to recommend the most suitable plan of rehabilitation for the individual.

Co-operation of the patient

I must stress again how essential it is to have the patient's full co-operation in his treatment. It is impossible for a patient to derive satisfactory benefit from any form of rehabilitation unless he is willing to play his part to the full, and it is this measure of co-operation that must first be won by the therapists. Two contrasting cases illustrate this point. The first is that of a young man with minimal physical disability, but poor

adjustment to his disability which is superimposed upon an inadequate personality. All forms of rehabilitation have been tried and have failed. He has had hospital treatment, physiotherapy, occupational therapy, spa treatment in England and abroad, a course at a medical rehabilitation centre, and a course at an industrial rehabilitation centre. Eventually, he was accepted in a sheltered workshop where he was tolerated as an unproductive member for about four years. At present he is unemployed, with the philosophy that he is a disabled person and his parents should support him and that, when this is no longer possible, it will be the duty of the Welfare State to continue this support. In contrast, a young middle-aged lady was referred to the hospital when her disease was active; she was depressed and dependent upon her family and unable to run her home. During the course of rehabilitation she discovered that she had the ability to write short stories, and she has now developed this skill and writes for the glossy magazines. She types with the aid of small splints which give her wrist support, and finds this work rewarding and remunerative: She has taken the family for holidays on the proceeds! These two people are perhaps not really typical but they do illustrate that the key to successful rehabilitation is motivation, incentive and co-operation on the part of the patient.

I should like now to turn to some of the more specific problems, and the way in which we as occupational therapists sometimes are able to provide a solution. I have divided the subject into three sections. The first is 'aids and gadgets' which includes ideas which will be familiar to many people here today. The second is 'adaptation and modification of methods and techniques' and, lastly, there are 'future designs and special adaptations'. This last group requires clarification. About three years ago a research bungalow was built by the Central Council for the Care of the Disabled as an extension to the occupational therapy department of the Mount Vernon Hospital. Here an occupational therapist and technician, together with a horticulturalist and an industrial designer, have been studying the specific problems of those disabled by rheumatoid arthritis.

Aids and gadgets

These include a stocking aid, simple but effective for those who are unable to bend, a pick-up stick, which has many uses, not only to pick up objects which are dropped on the floor but also for reaching things on shelves, a suction cross that sticks to the table top and will anchor the plate or the mixing bowl. A trolley is a valuable piece of equipment in the kitchen, and a tea pot on a little stand which tips as you push the tea pot forward, saves having to lift a heavy tea pot when pouring.

Adaptations and modifications of technique

Peg board is valuable in the kitchen; enabling utensils to be hung on hooks which can be moved easily to convenient heights and positions, according to the varying ability of the arthritic person. We have discovered in our studies at Mount Vernon that the disabled arthritic dependent on a walking aid prefers her kitchen to be small so that she is able to do her jobs without having to walk great distances.

With the addition of a thin foam mattress on top of the normal mattress and the use of lightweight bedclothes and cellular blankets the job of bedmaking becomes easy.

Frequently chairs are too low. People do evolve their own methods of getting out of them but a spring-assisted seat can sometimes help people to get up in the normal way. It may be comfortable to sit in a low chair and less conspicuous, but at the same time it is inadvisable for elderly relatives to be helping the disabled person up out of a chair.

Designs for the future and special modifications

These include a chair made by one of the occupational therapy technicians at Mount Vernon Hospital with the idea that it could be used for the assessment of patients and

their individual seating needs. It can be adjusted in all directions, the height and angle of the arms, the angle of the feet to the back of the chair, the height of the legs, and the front in relation to the back can all be adjusted. It was built essentially for assessment but it was found in using it that it became a valuable piece of equipment within the department; and if a manufacturer could produce it at a reasonable cost it would be a useful product, but so far it has not been possible to develop this idea. An industrial designer has studied the bath requirements of disabled people in the bungalow, by building a bath and lavatory out of polystyrene blocks with the idea that a series of experiments should be carried out. He has also made a prototype of a walking aid incorporating a parcel tray and a little shelf above, also a padded seat on which the disabled person can sit.

It is said that we are a nation of gardeners and there is no need for the disabled arthritic person to be deprived of the pleasure of gardening. Greenhouse cultivation is an interesting and rewarding hobby and can also provide occupation, with financial benefit. A raised flower bed can be made from paving slabs; the resulting container filled with earth brings the garden up to a more convenient level. At Mount Vernon there is a small amount of grass which all last summer was cut by various sorts of powered motor mowers, used by disabled people, it was necessary to reduce the speed of some of them so that they did not run away with the operator, but most of them the patients could manage. The manufacturers of garden tools have been interested in the studies that have been going on at the hospital, and have sent their designers down and as a result have now produced modifications to their standard tools with the disabled in mind which now makes gardening easier for anybody, not only the disabled. At the Chelsea Flower Show last year the Central Council for the Care of the Disabled had an exhibit of gardening for disabled people; including some wheelbarrows which are very useful as they serve as a walking aid having two wheels, and can be wheeled around with one hand. Bottle gardening is another cult of the moment, and can provide an interesting hobby for disabled people.

Rehabilitation and resettlement of patients suffering from rheumatical disorders

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If I could take up Dr Ansell's point on motivation: early work assessment and plans for resettlement are particularly valuable for patients who have disabilities that are complicated to assess and understand, particularly by the layman, and are variable, with a prognosis that is difficult to predict.

All patients that come into hospital are initially concerned about their future. The majority are worried about their jobs—this is understandable. To the majority of working people work is something they get involved with at about 15 years of age when they leave school and, all things being equal, this involvement will continue for the next 50 years until they retire. To them work is a means to an end; it provides for the everyday things in life. Their assessment of this is measured in terms of wage earning ability. What is the maximum that they can expect to get in return for their labour and skill? It follows that when they leave their normal environment and are