AFTERCARE AND REHABILITATION

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I will start by discussing briefly the question of the co-operation of hospital staff with the general practitioner. I am putting this point first, because it seems to me that such co-operation is often defective in quantity and quality. On the other hand, when it is developed into an active partnership the results can be most rewarding. It has been our custom for some time now to contact the general practitioner whenever a prescription is needed for a patient of his who is attending for treatment in our rehabilitation centre. Perhaps something is needed for insomnia or pain. The doctor then sees the patient and becomes an active member of the team treating him. Often the doctor can help in his patient's programme by explaining some relevant detail that the rest of the team would otherwise not know about. Frequently we find that the general practitioner can add some encouragement that may make all the difference to rapidity of recovery. I believe there is a great field for development along these lines, and meetings such as this should go some way towards correcting the present estrangement of doctors practising in the hospital service from those outside it.

The need for a rehabilitation service is now well established. You will notice that I use the word " service " and not " centre ". I have done so deliberately to emphasize that the service is so much more important than the centre. We have heard a good deal about the practice of twentieth century medicine in nineteenth century buildings, but it seems to me that some of the best medicine is practised without the benefit of modern architecture. In fact, I know some general practitioners who had developed the art of rehabilitation long before this word was discovered. Let me put it another way. Ninety-nine per cent of all persons with major injuries in our area return to work without attending the rehabilitation centre. But the rehabilitation team are involved in every case. This means that medical and nursing techniques have to be adjusted to allow normal activities in the early stages after entry. For example, in the treatment of a fractured clavicle, selected activities are possible the day after injury, provided the fracture is held by an efficient bandage and the disabling arm sling is not used, or the long leg walking plaster for treatment of leg fractures is hinged at the knee

so that the patient can get on a bus or ride a bicycle, and so that he can get to his place of work. It is necessary for one member of the team to contact the works to explain that although that employee is injured he will be able to return to work immediately with some modification or selection of work. The success of such an arrangement will depend entirely on how well it is put over. It is essential to explain to both patient and employers that a return to work is treatment, not only that but the most important part of treatment. I could spend the whole of my allotted time this morning telling you of the arguments we still have to use to persuade the work-shy employee or the absentee landlord employer that work is an essential part of treatment, but it probably is not necessary because no doubt many of you practise this anyway. So we have a service for a majority of our patients with major injuries and we need a centre for the small minority.

It was not always thus. At one stage towards the end of the war when enthusiasm for rehabilitation had reached dizzy heights I had a patient, a dentist, with a crush fracture of the first lumbar vertebral body, which was reduced and put in plaster. He was in the Forces and we sent him back to his job several weeks later. All went well until about six weeks after his return to work the Forces Rehabilitation Officer caught up with him and whisked him off to a rehabilitation centre. It took the combined efforts of the C.O. at the local barracks, who had to cope with an increasing number of troops with toothache, and several of my more sensible service colleagues to persuade the rehabilitation officer to release this much needed man for duty, and incidentally a much better form of rehabilitation. This is my first main point. The best form of rehabilitation is normal activity. The dentist I have just spoken about was happier at his work than he was in a special centre with elaborate but artificial programmes of activity. This man knew that he was needed by his patients and he was not pleased to join a group of other service men and spend most of his time in a gymnasium. All of us and the vast majority of our patients believe that we are important in our jobs. The wheels cannot possibly run as smoothly without us, and the happiest of all of us innocently believe that the wheels would stop altogether if we were not there to keep them going. Today, we realize that what matters is not admission to a rehabilitation centre, but the advice and interest of a team of rehabilitation experts. We are seeing the wisdom of the pioneer work of Mr Gissane, who showed that industrial methods could be used to advantage in the rehabilitation of that one per cent of injured persons who require admission to a rehabilitation centre. Thus the service brings industry into the treatment partnership. The centre provides the atmosphere and remedial exercise for the

one per cent that cannot get to work, and such patients are occupied all day and every day, and do not lose the work habit. The more we understand this, the less clinical material there will be for future psychiatrists.

To complete the picture of the functions of the rehabilitation team, I must mention the work of the disablement resettlement officer and the almoner, and the fascinating work done by the medical interviewing committee and resettlement clinics in which the general practitioner has an important part to play. No accident service can function properly without one or other of these committees. Principles of rehabilitation are becoming clearer with the experience of the past fifteen years in the treatment of injuries. First, there can be no doubt today that the best form of rehabilitation is normal acitivity in familiar surroundings and in the company of usual work-mates, with some modification and selection of activities at times. Second, we are becoming increasingly aware of the fact that getting well after a major injury is a full-time job, requiring purposeful activity all day and every day. Third, industrial methods have a distinct advantage over other forms of occupational therapy, not only on economic grounds but psychologically as well. Fourth, this is a highly personal service, and each person has an individual target and his own programme. Finally, rehabilitation and resettlement for the injured who have an appreciable residual handicap should be one continuous process. At present there is a time lag and a distance lag between medical rehabilitation in hospital and the industrial rehabilitation services provided by the Ministry of Labour. You will probably be interested to know that the Ministry of Labour and the Ministry of Health have joined forces and have planned an experimental centre in Glasgow where these two activities will be integrated. It means that assessment and rehabilitation will go hand in hand, and as soon as it becomes obvious that re-training is going to be required, such training will be started without further waste of time. It will take place while the person is still on treatment. This promises to be one of the most important new developments and may make a great difference to the lot of the disabled person in the future.

I would like to say something about average time off work for the standard injuries. Your chairman was asking for a definition of major injuries and I would put fractured big toe into this category purely on economic as well as social grounds. At the Vauxhall works where we have developed this rehabilitation service to its maximum, one man was off work five and a half days with a fractured spine, and he volunteered at the end of his treatment that his back was stronger than it ever had been. And, incidentally, he got a

perfect result and £2,500 compensation. Many years ago I copied Mr Gissane's ideas on industrial rehabilitation, and one of our appliances is a small milling machine which is operated by a below-knee stump. For example a patient can operate the machine eleven days after amputation with his stitches still in and his bandage in place. When he tries to operate his machine the stump is straightened and he gets perhaps 2,000 quadriceps contractions a day.

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The title of this paper is " Rehabilitation and Aftercare "; there is not a word about resettlement, not a word about adjustment to chronic handicap, the putting up with the handicap or the adjustment of the person's ego to it and of the family to a diminished wage. Also it is spelt with a capital " R " so let us have a definition. Can I borrow one from Browning? " Rehabilitation is the process of returning a man, woman or child to a normal healthy position in the social structure after they have been dislodged from it for one reason or another ". The other side of the coin is the dehabilitation which is the signing off work, the signing on to the sick fund; this could be defined as the process of dislodgement from a normal healthy position in the social structure. This can be related to divorce, separation, illegitimacy, chronic unemployment, leaving school, National Service, and changing jobs. But for our purpose, it is leaving the job when the person is signed off sick. We are then essentially dealing with a social process of taking the individual out of a setting he has been used to, taking him off his tram lines, when we sign him off sick. We are de-socializing him, because today, in a complex industrial technological society like Birmingham, about the only root the man has is his job, his little group of workmates. This is the place he has most contact with. In the old days