REHABILITATION

WELCOME

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IT IS my very pleasant duty to start these proceedings by welcoming all our members, and more particularly our guests, on behalf of the South-east England Faculty, to this symposium on a subject so important to all of us in practically every branch of medicine—rehabilitation. It remains for me to introduce the chairman of our morning session, Lord Robens, Chairman of the National Coal Board, who is also a governor of the College at which we are holding this meeting, and to hand over the conduct of this session to him.

Lord Robens: In my capacity as a governor of the Queen Elizabeth Training College for the Disabled, I give you a warm welcome indeed to the College and say how much we appreciate the selection of the College for this particular symposium. Stanley Evans and I have worked together over many years at the College, but I did not think at the time I joined him here that I would eventually become the biggest supplier of material. This is unfortunately the case. Probably my industry injures more people in the course of a year in proportion to the numbers of people employed than any other single industry in Britain, and therefore the question of rehabilitation, a subject which has been of tremendous interest to me from the days when I was Minister of Labour and tried to do something in the department about improving the position, has become a constant one with me; today it is even more important in

terms of urgency. We have a very distinguished list of speakers today and the first is Mr Stanley Evans, about whom I will say nothing except that I know of no man who has done so much in this field. He is going to open our proceedings by speaking on the " Approach of rehabilitation services ".

APPROACH TO REHABILITATION SERVICES

Stanley Evans, *C.B.E.*, M.B., F.R.C.S.

(Consultant Surgeon, Lord Mayor Treloar Orthopaedic Hospital, Alton; Chairman of the Queen Elizabeth Training College for the Disabled)

As we are meeting at the Queen Elizabeth College, I would like to say a few words about it and its associated services, because it does provide a sound basis for the rehabilitation of the very severely handicapped. I am going to deal with the problem in a very general way, because speakers who follow me will deal in greater detail with the particular processes and methods involved in rehabilitation and with specific problems. Queen Elizabeth College was opened in 1934 to provide short-term training for the very severely handicapped in order to equip them for employment in open industry. Since the early years of the century, there had been training colleges providing long-term training designed for adolescents and younger men and women but this college from the very beginning dealt with men and women of practically all ages. During the last war when every pair of hands was needed, men of 60 and 65 were trained for employment. There are upwards of 200 disabled men and women here, and over 7,000 have been trained for employment and successfully placed in open industry. There is a large variety of trades and occupations; I need cite only a few: gardening, commercial subjects, spray-painting, radio and television, welding and draughtsmanship. There is a great variety for three main reasons: (1) All kinds and conditions of disability are dealt with, and therefore we have to fit the disability to the particular job or occupation; (2) the trainees come with varying degrees of educational background and attainment; (3) the individual choice of the disabled

person must be considered. Therefore a wide variety of trades is needed, and at present there are 16 courses. The disabilities dealt with vary tremendously. Initially the trainees were practically all orthopaedic, but now there is a large number of trainees with neuromuscular disorders, cerebral palsy, paraplegia, epilepsy and so on. The success of the College depends on the fact that for the older men and women short courses of from six months to about a year have been provided; they would not have taken advantage of three-year courses. Associated very closely with the College is Dorincourt Estates. Some of you may have noticed in the main hall a number of rather beautiful decorative tiles round the walls; they are examples of the work done at Dorincourt Estates which essentially consist of three parts. The first is Banstead Place, a medical rehabilitation centre opened in 1956 for 32 disabled men and women under the joint sponsorship of the National Association for the Paralysed and this College. Primarily, the young chronic sick are dealt with, and it is virtually a rehabilitation centre designed to equip the residents for daily living, to meet the demands of their disabilities and to live with their disabilities. The second is Dorincourt, within a stone's throw of this College, which was opened in 1958 and provides sheltered employment and sheltered living conditions for over 40 seriously disabled men and women. They are so handicapped that they cannot be trained at this College for open industry, and consequently they are provided with sheltered employment, either in pottery or in engineering assembly as outwork for factories in the surrounding district. The third is Lulworth Court at Westcliff-on-Sea which was opened in 1959, by the National Association for the Paralysed, in order to provide holidays for the very severely handicapped who would otherwise find it impossible to have one. These three units of Dorincourt Estates and this College offer a comprehensive basis for the rehabilitation of the severely disabled, and there is no doubt the services provided fill a great need. They are but a prototype of what ought to be done, and there is need for many more such foundations in the country.

I am going to suggest that rehabilitation consists of all the agencies used to attain or restore optimum function and physical and mental independence, and that it starts at the time of the accident or sickness. The services include medical treatment, the ancillary therapies of various kinds, the social services (including almoners and health visitors), the local authorities, the government departments and various voluntary agencies. If the facilities are not very good, we are faced with a much more serious and difficult problem.

I would like to say a word about the role of the family doctor in rehabilitation. Firstly, he has to cope with very large numbers who need rehabilitation or some form of treatment or help in recovering

from sickness or accident and whose condition is serious enough for him to be referred to the various rehabilitation services. He may well have to deal in quite a comprehensive way with rehabilitation services in the home, bringing in the district nurse, the health visitor, the local authority, and getting help in various directions.

Secondly, the practitioner has to cope with those who have concluded their course of rehabilitation and have returned to their home. I believe there is a great need for much closer participation by the family doctor in the rehabilitation services. There is not enough interchange, as I am sure you will all agree, between the family doctor on the one hand and the hospital services on the other. I would like to see a far closer link between the family doctor in the hospital, clinic and rehabilitation services on the one hand and the specialists taking part in domiciliary rehabilitation on the other. Help for individual disabled persons can be obtained from the welfare departments of local authorities, and adaptations can be carried out in the home, and in particular in the kitchen for a disabled housewife, and in the bathroom and lavatory and so on. These can be done by the welfare department at the expense of the local authority, and rehabilitation experts can visit the home and indicate the ways in which this help can be provided. Dr Russell Grant of Winchester has played a prominent part in this sphere on the domiciliary side. Aids and gadgets come under the same category and are also very helpful.

Thirdly, the general practitioner should be encouraged to take part in case conferences on his own patients. I would be the last to advocate any more committees or more committee work for anybody. I agree with the definition of a committee as " consisting of the unwilling chosen from the unfit to do the unnecessary ", but I think there is a place for the general practitioner in these case conferences and that he should know exactly what is being recommended for his own patient.

I have no time to deal at length with the disabled child and adolescent, but I feel strongly that a disabled boy or girl needs education of a higher standard than the ordinary able-bodied child in order to compensate for the disability. With that end in view there is now at the Lord Mayor Treloar College a residential grammar school for disabled boys from the age of 11 to 16 where they can work for their G.C.E. at ' O ' level and where we hope they will later be able to go on to 'A' levels and university careers. We are now building a similar school for disabled girls, also in connection with the Lord Mayor Treloar College. We have hitherto neglected this particular aspect, and have not widely trained the disabled for the professions, university careers, or for the technological colleges.

Many of these disabled boys and girls are very able intellectually, and it is their " brains " we should take advantage of when they are limited physically.

For the disabled adult there is no doubt that daily living often presents a far more difficult problem than training for a job. For example, a paraplegic in a wheelchair with normal hands and an average brain can be trained very readily for many sedentary occupations, but the problems of getting up, bathing, dressing, making breakfast and getting off to work can be much more difficult than doing his job satisfactorily. Therefore, when we provide sheltered employment we must also provide sheltered living conditions. I would like to see many more hostels provided in the country for those unable to live in their own homes who can do a good job of work and who need help in daily living. We need hostels like the Duchess of Gloucester Home in the Great West Road, where the severely disabled can live comfortably and can have any help that is necessary and then go out to the work for which they have been trained.

On the whole I think it is generally agreed that the rehabilitation services in this country are second to none in the world, but of course there is room for improvement. Firstly, more attention must be paid to the prevention of accidents in the home, in industry and on the road; as we can thereby lessen the demands on the rehabilitation services, which are continually rising due particularly to the increase in high-velocity accidents. Secondly, there is a need for an organized accident service on a national basis, as advocated by Sir Harry Platt and his committee, so that highly skilled surgeons rather than inexperienced housemen are available to deal with severe accidents. When we have a national network of district hospitals and accident services throughout the country we shall have fewer demands on the orthodox rehabilitation services. Thirdly, better and more comprehensive facilities for the education of the severely disabled are required. Next, greater attention must be paid to the design of homes and public buildings to provide access for the severely disabled, particularly the chair-bound. So often nowadays they cannot get into public libraries, the town hall or cinemas and theatres; public lavatories cannot be used by the severely handicapped and chair-bound. Greater attention can be paid to this because if they are accessible to the disabled it does not make them any less so for the able-bodied. With the ever-increasing geriatric problem we need more buildings designed to enable the disabled elderly ready access to them. A tremendous amount of help is available and it is for the family doctor to see that this is provided by the welfare authorities by way of adaptations in the home and the provision of aids and gadgets. Closer co-ordination and teamwork by those

engaged in the rehabilitation services is required to take full advantage of the facilities provided by the government, local authorities and voluntary agencies.

Lastly and most important is the need for closer integration and consultation at all levels between hospital services, public health authorities, and the family doctor, as stressed in the Porritt Report. These bodies should get together in order to provide a comprehensive and dynamic national rehabilitation service. We in this country are I think ahead in this field at the moment and if we are to stay there, we must attend to these problems which are so important, for their satisfactory solution will enhance the already high reputation this country holds in this particular field.

Question: The speaker spoke of the Westcliff holiday home. What would be the procedure to get a patient there for a short stay?

Mr Evans: Make application direct to the Director, Dorincourt Estates, Leatherhead, Surrey.

REHABILITATION IN THE ROYAL AIR FORCE

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I am to talk on the rehabilitation services in the Royal Air Force, and a little historical background might perhaps be of interest. The idea of organized inpatient residential rehabilitation goes back to the end of the 1914-18 war when Sir Robert Jones opened in the basement of the Shepherds Bush Hospital an occupational therapy department, a *true* occupational therapy department where disabled soldiers actually used work for getting themselves better. Although a great pioneer achievement, this did not attract much notice, and between the two wars very little was done in this field, though there was a centre for railway workers in Crewe opened by H. E. Moore.

During the early part of the 1939-45 war, the Air Force was confronted with the problem of their pilots and other air crew, as well as ground servicing crews being off work for long periods through injury. The combination of outpatient physiotherapy and sick leave was not getting these people back to flying or to servicing