What Contribution Can Medicine Make to Community-based Rehabilitation?

Prof. Lindsay McLellan*

Introduction

This lecture is given from my perspective as a Professor of Rehabilitation in the Medical School of Southampton which is near the south coast of England about 110 km from London. I was initially trained as a neurologist but moved to my present post in 1984. Like most clinical academic staff in British Medical Schools, I have an honorary contract as a consultant in the National Health Service, and together with two colleagues am responsible for a small rehabilitation ward of 14 beds, a short-term residential unit for disabled adults under the age of 65, and an outpatient service serving a population of about 420,000 people. I am also involved in some of the planning and setting of objectives for rehabilitation services in our region which covers a population of about 2 million people. As well as teaching medical students, we run an M. Sc. course for graduates of the health-related professions of whom approximately one-third come to us from overseas.

Disability in the Population

If visual and hearing impairment and learning disability ("mental handicap") are included, 14% of the British population have some form of disability and about 0.5% of those under the age of 65 are likely to have a disability sufficiently severe to render them incapable of living at home for 24 hours or more without help from another person. Over the age of 65 the proportion is much higher and rises steeply in the very old.

Medical practitioners want to group their patients according to their medical diagnosis, and so for us it is helpful to know that disorders of the musculo-skeletal system are the commonest cause of disability, followed in decreasing prevalence by disorders of the ear, eye, nervous system and circulatory system. For those having to live in residential accommodation rather than in their own homes, the commonest cause of disability are disorders of the central nervous system. This seems to reflect the very wide range of different impairments and disabilities that can be caused by nervous system disease, especially when a physical disability co-exists with impairment of cognitive function or behaviour. Another way of categorizing disability is by function rather than by pathology. Locomotion is the commonest functional disability in our population, followed by disabilities of reaching and stretching, dexterity, seeing, hearing, personal care, continence, communication and behaviour. If behaviour and intellectual function are considered together, they become the second most prevalent category of disability after disorders of locomotion.

The speciality of rehabilitation medicine in

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*Professor of Rehabilitation, University of Southampton
the United Kingdom has as its principal forms 3 groups of people: (1) those with complex (physical and cognitive) disability, (2) those whose disabilities require technically complex solutions (e.g. amputees), and (3) those undergoing transitions between different stages of life or between different levels of disability. Most specialists have completed higher medical training to MRCP level but some have FRCS training.

Plan of this Lecture

In my talk this afternoon, I shall suggest that the contribution that medicine can make to community-based rehabilitation falls into 4 parts.

The first way is the analysis of information about the population of disabled people and the planning and auditing of services to meet their needs.

The second way the medical profession can contribute is to work very closely as a member of a team with other professions in the assessment and rehabilitation of individual patients.

The third way is education. We need to educate students and graduates of our own profession about rehabilitation and we can also contribute to the education of the other professions with whom we work. We can also help educate the general public in order to bring about a more general awareness and acceptance of the needs of disabled people, and of the contribution they can make to society if not prevented from doing so by people who are not disabled.

Finally, we can contribute in the field of research because of our scientific training, the breadth of our interests as speciality in rehabilitation medicine and the close working relationships we have with the other professions in this field.

The British government has for some years now been seeking to reduce costs and increase efficiency in its public services. As a result of better medical treatment and better community services, patients including geriatric patients stay in hospital for a much shorter time than was previously the case.

The change has put a great strain on the carers and families of disabled people. For example, my colleague Dr. Cantrell working with a social worker looked at people in Southampton under the age of 65 years and found a high percentage of problems as this slide shows. The figures relate to people who were unable to live at home without the assistance of another person within each period of 24 hours.

People with disabilities in the United Kingdom as in other countries have clearly stated that they nearly all wish to remain in their own homes rather than move into residential accommodation, yet the number of places in private nursing homes is still increasing. How can this wish be met?

Care Attendant Schemes

As a result of Dr. Cantrell's work in Southampton, the district health authority set up a "care attendant scheme", initially for those under the age of 65, in which basic physical care of the kind provided by a person's family was given, initially, by paid community staff. The scheme is run by community nurse with some rehabilitation training; initially it was funded by the health authority but now it is funded equally by health and local social services funded by the government. The service is based on a disability register, which includes basic information about all the people in the district who need help in order to live at home whether this help is provided by their own family or not. The nurse coordinator visits the home every 6 months to reaccess the situation and works out a care timetable with the disabled person, and agrees to provide help for specific periods of the day for essential activities such as getting up, feeding and so on.

This care is provided by paid staff who usually do not have a professional qualification but
have a short training from nurses and therapists sufficient for them to provide basic help and to be able to report to the coordinator if problems are occurring for which professional help is needed.

The following slides illustrate the nature of the support that this scheme can give to people in their own homes, helping them to remain there and experience as full and normal a range of activities as possible, while providing respite for the carers.

Care attendant schemes are now widespread in the United Kingdom and are becoming increasingly available for elderly people as well. They are often funded jointly by local health and social services and are run in close collaboration with them.

These schemes do not attempt to provide comprehensive rehabilitation in the person's home. People for example recovering from head injury who have a long time-course of recovery need not only ease but rehabilitation in the community in order to reach other optimal potential.

We have recently worked with planners in our local health and social services to establish a register of people living at home after a severe head injury in order that their progress can be systematically monitored and their needs for rehabilitation support—which are often of a psychological or social rather than a physical nature—can be better defined, and we can ensure that all who need it are referred to our community rehabilitation team.

These are just 2 examples of the contribution that rehabilitation medicine can make to the planning and monitoring of services. A third example is the charter for disabled people using hospital, recently published by the Royal College of Physicians of London and the Prince of Wales' Advisory group on disability, an organization which represents the views and interests of disabled people and their families. This charter sets out standards for hospital facilities which (we hope) will lead to better recognition of the needs of disabled people whether they are patients or whether they are simply visiting hospitals.

**Teamwork**

The second way in which the medical profession contributes to community-based rehabilitation is in teamwork with the other professions involved in assessing people with disabilities and providing therapy.

In hospitals, it is relatively easy to ensure that good teamwork takes place and in the United Kingdom, teamwork is better developed in hospital rehabilitation units than in most community services. The principles of teamwork are the same in both environments, as shown on the following slide.

Such teamworking is expensive in staff time but it is absolutely essential in order to ensure that we all agree on the same objectives. While recognizing the particular expertise each profession has, it is necessary for all of us to cross traditional boundaries between our professions in order to provide a service that is efficient and comprehensive to the patient. A good example of new ideas is that of the child with cerebral palsy who according to traditional practice may need to relate to many different people. "Conductive education" employs a teacher trained also in therapeutic principles who may combine the skills of several professions across a relatively specialised and restricted field of disability such as cerebral palsy. Such models of care and rehabilitation need to be continuously tested and developed.

In my own unit, once patients are discharged back to their own homes, they may continue to have regular contact with therapists, their social worker, or our clinical psychologist, and we meet every 3 weeks or so to discuss the patient's prognosis. Recently I have tried to reduce the need for people living at home to visit my hospital clinic by sending a liaison therapist to the patient at home. This saves the
patient travelling to hospital and in the security and familiarity of their own home, the patient is often able to talk more freely to the therapist —and to have a longer time for discussion —enabling more problems to be explored. The therapist then discusses his findings with me and by this means we have been able to halve the frequency with which people with disability have to attend hospital clinics.

Despite many methods of working, a number of problems remain and it is important that I share them with you. Some of our problems are indicated on the following slides.

**Education**

The third general way in which medicine can contribute is in education. First, those of us interested in rehabilitation medicine need to contribute to the training of our own undergraduates. Our textbooks still give information about disability as these slides show. Second, we need to develop much more shared education with the other professions with whom we work. Our therapists, social workers and clinical psychologists in Southampton help in the instruction of medical students and we have just appointed our first senior academic parts in occupational therapy and physiotherapy. By 1993 we shall have undergraduate students of these disciplines as well as nursing within our faculty of medicine and we shall be moving in practice—if not yet by name—towards the model of a faculty of health service. I believe that it is essential for such shared education to increase if we are to work effectively in our colleges in other disciplines after qualifying.

**Research**

Finally, there is the vitally important matter of research. There is an enormous need for more research in the field of rehabilitation and our profession must take a lead in this because of our present advantage in our tradition of breadth of our approach. But we need to become familiar with research methodologies appropriate to therapy, some of which have been developed by other fields such as cognitive and behavioural psychology and social service. In the United Kingdom one of the difficulties in obtaining research funds for disabilities is that of research committees.

We are stuffed by medical practitioners who believe that the double blind controlled trial is the only valid scientific instrument for clinical research. This is not the occasion to debate this important issue, but I think it is pretty clear that such trials may be an inordinately expensive, wasteful and inappropriate way of studying rehabilitation.

We need to establish interdisciplinary research teams with our colleagues from other professions with sufficiently secure and long-term funding for expertise to be consolidated, in order to increase the rate of progress in rehabilitation research.

In this I believe that the care structure open to us in academic medicine, where a doctor can be employed by a university but still combine clinical practice with training and research, is a good model for the distribution of therapy and clinical psychology. We must help these other professions develop similar career paths for their academically gifted professions, whether they are therapists, nurses, engineers, social workers or psychologists, so that we can undertake research together with them on the many fascinating problems in rehabilitation which we still have to solve.

**Conclusion**

Rehabilitation is in many ways closer to education than to the process of traditional medical and surgical treatment. The cultural context of the disabled person, the family and those of us who wish to help them is an essential and integral component of rehabilitation. This means that research into rehabilitation
across different cultures and countries could reveal important and unexpected truths and open new avenues of research.

I am particularly grateful to Dr. Sawamura and to the British Council for the opportunity of attending this congress and of learning more about community-based rehabilitation in Japan. This is bound to challenge my present ideas, and will stimulate me to change them. I hope that this lecture has gone a little way towards returning this compliment to your Association.

(文中, スライドは省略しました：編集部)