REHABILITATION AND EMPLOYMENT.

By Dermot Roden, M.D.

Mater Misericordiae Hospital, Dublin.

SINCE the introduction of a scheme to rehabilitate the injured and those suffering from disease is now under active consideration by the Minister of Health, an examination of some aspects of this problem may be of interest.

Medical science as it relates to the patient can be divided into three phases, viz., prevention of disease, diagnosis and treatment, and the functional return of the patient to the active life of the community. The first and second phases have made rapid progress, so much so that often physicians and surgeons become so engrossed in treating the disease that the patient is apt to be forgotten.

The purpose of physical rehabilitation is to achieve the maximum function and adjustment of the individual and to prepare him physically and mentally for the fullest possible life compatible with his abilities and or disabilities. This is largely the responsibility of the medical profession.

Beyond this point our responsibility ends, but the problem of rehabilitation is not finished until the patient is again earning his livelihood. It must be realised that the industrial section of the community has a responsibility because industry must take the finished product and, by careful and selective placement, use these individuals within their capabilities. Factory management must understand that rehabilitation is a service that should be available to all citizens as a right; private individuals, social agencies, government departments, insurance companies and, not least, our own profession must be made aware of the opportunities available in a national rehabilitation scheme. All must realise that through such a scheme handicapped individuals may be transformed from dependent invalids into contributing, self-supporting, self-respecting citizens.

Patients who require rehabilitation may be divided into six groups: the blind, the deaf, cardiac cases, the tuberculosis, the neuropsychotic, and those classified as orthopaedic. Nearly all patients suffering from disease or injuries involving muscles, nerves, joints and bones fall into the last group, and a large part of their treatment is carried out in a department of physical medicine. This group also represents the largest number of patients requiring rehabilitation, and it is in this group that industry loses so heavily in man-hours and in compensation.

Practically all patients in the orthopaedic group should start rehabilitation before they leave hospital. To do this, every large hospital should have an adequate department of physical medicine, with a physician in charge. It is not practicable for patients to remain in hospital until such time as they have reached the maximum degree of rehabilitation. It is possible, however, to teach most patients to walk and travel and care

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for their daily needs. Many patients on leaving hospital are able to return to their former employment; some will need months of further care. Others will have to be re-trained in new work because of their disabilities. Others will not be able to return to industry, but could still work in sheltered workshops. About 3 per cent. of the injured will never be able to work except in their own homes.

What is to happen to those who cannot return to work? There exists a need for a service to care for these, also to fill the gap between the time when the others leave hospital and when they are fit to work. This is being filled in some countries by the Rehabilitation Centre, a centre organised and equipped to continue the rehabilitation programme begun in hospital.

This centre has a department of physical medicine in which physicians and physiotherapists study the medical and physical needs of the patient. If a psycho-social problem is present, it is analysed and dealt with by a psychiatrist, who has a staff of social workers to help him. Vocational counsellors and training officers with workshop facilities investigate the skill and aptitude of the patient. When the patient’s physical, mental, social and vocational evaluation has been made, it is possible to decide whether, after a period of reconditioning, he can return to his former employment, needs training in a new vocation, or is limited to employment in a sheltered workshop, or must be dealt with in what has been called the “home-bound” service. Patients are rehabilitated by attending and working at the centre for increasing periods each day, up to the date on which they return to work.

Very few persons, after a period of illness, are able to do an adequate day’s work without gradual reconditioning. Strength and endurance are not acquired by resting. It is only by increasing the daily amount of physical activity that the essential needs for work are gained. The present method whereby patients with orthopaedic disabilities receive physiotherapy for half to one hour daily is not satisfactory. It is far too slow in accomplishing results. Patients often develop mild neuroses and a disinclination to return to work. These difficulties would not arise and the patient would get well quicker if he were kept busy most of the day at a centre, staffed by physicians, physiotherapists and the different mechanical technicians.

The basic needs of these patients may be grouped under three headings, which should be constantly in the mind of the rehabilitation physician:

(1) The ability to walk and travel;
(2) The ability to care for their daily needs;
(3) The ability to attain maximum use of their hands.

No patient should be discharged from medical care until these three objectives have been attained to the fullest degree possible.

The other groups and some diseases in the orthopaedic group, e.g., spastic paralysis in children, require specialised, often institutional care, and it is more desirable to segregate these, providing separate centres for each group. However, all centres conform to the same general plan.

Ideally a rehabilitation centre should be situated within easy reach of the homes of the patients, as most of them will attend as outpatients. However, there should be ward facilities for those unable to travel.