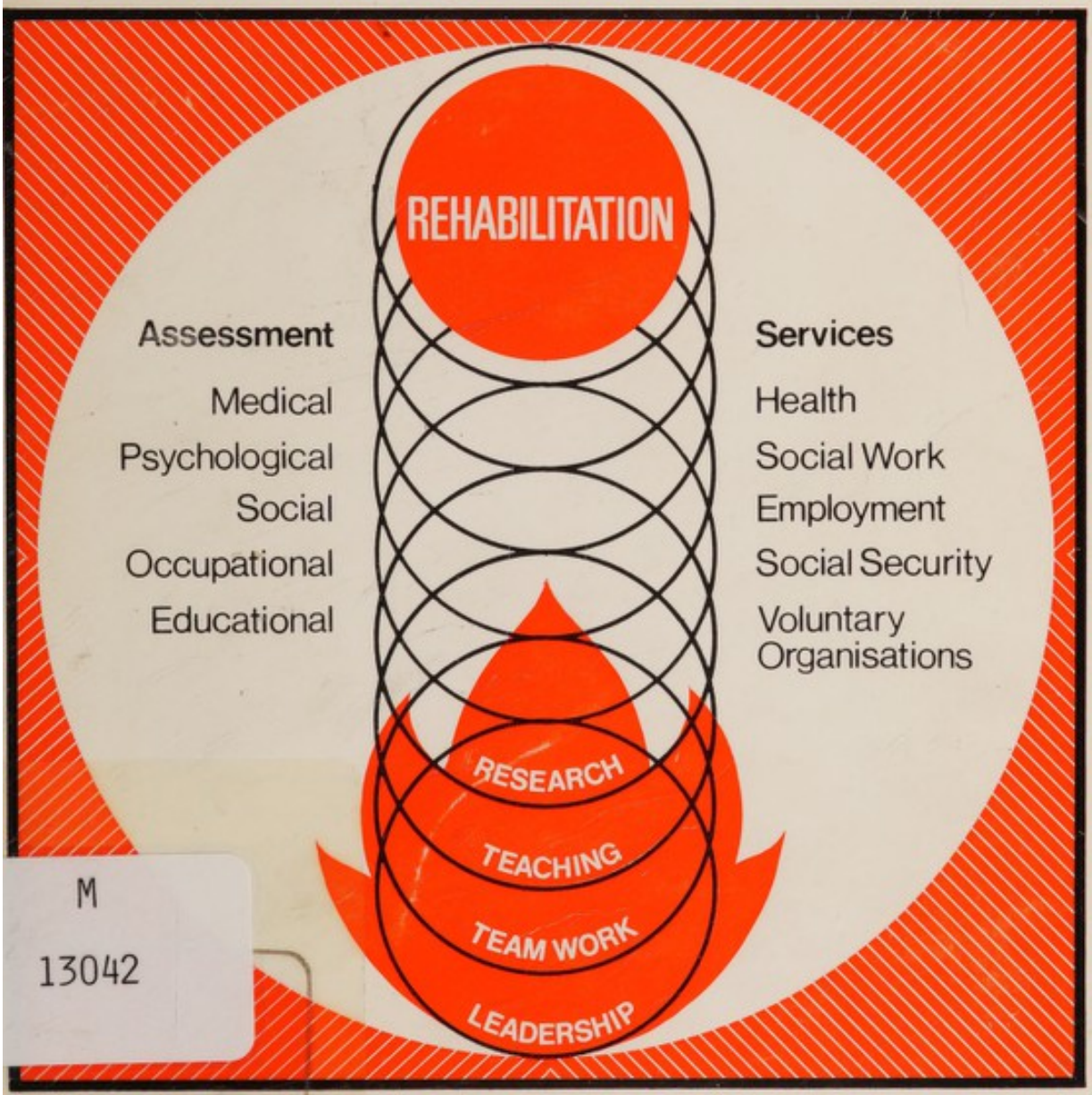
Medical rehabilitation : the pattern for the future / report of a sub-committee of the Standing Medical Advisory Committee.

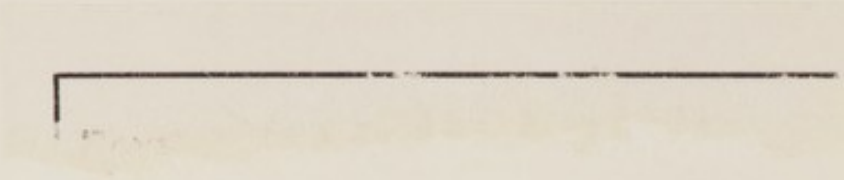
SCOTTISH HOME AND HEALTH DEPARTMENT

SCOTTISH HEALTH SERVICES COUNCIL

Medical Rehabilitation: the pattern for the future



A SUB-COMMITTEE OF THE STANDING MEDICAL ADVISORY COMMITTEE



SCOTTISH HOME AND HEALTH DEPARTMENT

SCOTTISH HEALTH SERVICES COUNCIL

Medical Rehabilitation:
the pattern for the future

Report of a Sub-Committee of the
Standing Medical Advisory Committee

EDINBURGH
HER MAJESTY'S STATIONERY OFFICE
1972

A

Members of the Committee

Professor Alex Mair, MD, FRCP (EDIN), DPH, DIH (*Chairman*)
Dr J. W. Affleck, MB, CH B, FRCP (EDIN & GLAS), DPM
Professor W. F. Anderson, OBE, C ST J, MD, FRCP (EDIN, GLAS & LOND)
Dr T. Y. Bennie, MB, CH B, DPH
Dr G. G. Browning, MB, CH B, FRCP (GLAS), DPH
Dr H. M. Caldwell, MB, CH B (EDIN), MRCGP, D OBST RCOG, (from March, 1971)
Dr A. P. Curran, B SC, MD, FRCP (GLAS), DPH, DIH
Professor J. J. R. Duthie, MB, CH B, FRCP (EDIN)
*Dr W. W. Fulton, LRCP, LRCS (EDIN), LRFPS (GLAS), FRCGP
Professor J. H. Hutchison, CBE, MD, FRSE, FRCP (LOND, EDIN & GLAS)
Dr T. W. Manson, MB, CH B, DIH, MRCGP
Dr P. H. Merry, BM, B CH, MRCP (EDIN), D PHYS MED, D OBST RCOG
Dr W. A. Murray, OBE, MD, FRCP (EDIN), DPH
Professor A. M. Rennie, MB, CH B, FRCS (ENG & EDIN)
Professor I. M. Richardson, JP, PH D, MD, FRCP (EDIN), DPH, MRCGP
Dr G. B. Shaw, B SC, MB, CH B, FRCP (GLAS, LOND & EDIN)
Dr M. M. Whittet, JP, MB, CH B, FRCP (EDIN & GLAS), DPM
R. B. Wright, Esq, DSO, OBE, B SC, CH M, MB, CH B, FRCS (EDIN & GLAS), FRCP (LOND)

Dr W. K. Henderson, MD, FRCP (EDIN) (*Assessor*)
Dr I. M. Macgregor, MD, FRCP (GLAS), DPH (*Assessor*)

*Miss Norma Christie, AIMSW (*Observer*)
Miss M. M. McInnes, AIMSW (*Observer*) from October, 1970

*Dr Fulton resigned from the Sub-Committee in November, 1970
*Miss Christie resigned from the Sub-Committee in September, 1970

Dr H. Miller, MD, DIH
D. A. Peters, Esq, MA, DSA, AHA } *Joint Secretaries*

SBN 11 490793 5

Contents

Preface

1 The Sub-Committee was appointed in October, 1968 by the Standing Medical Advisory Committee of the Scottish Health Services Council, with the following terms of reference:

> To consider ways and means of achieving an active rehabilitation approach which will permeate the medical care system, and in the light of this to make recommendations on the future organisation and development of rehabilitation services in Scotland, including the number and training of personnel required to provide these services.

2 The first meeting of the Committee was held in December, 1968, and in all 21 meetings were held. Members of the Sub-Committee visited hospitals, medical rehabilitation units, an industrial rehabilitation unit and the University Hospital of Wales. In adddition, a group of members visited certain countries in Europe to study the development of rehabilitation services abroad, while three members took the opportunity to visit centres in Canada and the United States during visits unconnected with the work of the Sub-Committee.

3 At an early stage we sought to define the central basis of our terms of reference. Rehabilitation is a concept whose meaning varies from the precise to the vague, according to individual taste, practice and experience. In the past, it was frequently taken to mean the application of physical methods of treatment aimed at restoring local function and general fitness after disease or injury. In recent times, a much broader meaning has been given to the word, which now implies the whole complicated process of the restoration of individuals rendered unfit from any cause to a degree of social and economic independence, within the limits imposed by any residual restriction of function. For the purposes of this report, the following simple definition was adopted:

> Rehabilitation implies the restoration of patients to their fullest physical, mental and social capability.

4 Health is a state of equilibrium between the individual and his environment. Illness or injury operates to disturb this equilibrium, and handicap may be the outcome of such a disturbance. The correction or alleviation of handicap may therefore be achieved by activities directed both toward the individual and his environment. Rehabilitation must therefore take cognisance of the individual and his environment, in order to restore him to his former status or 'balance'. It is concerned with the interaction between the disease, the individual, the community and the environment, and requires a broad ecological approach to care. Establishment of an accurate medical diagnosis

is only the first step. Many needs can only be identified by agencies outwith the health services. Assessment of disability and its correction requires an integrated team, with knowledge of medical, social, educational, psychological and vocational factors. In this multi-disciplinary approach, communication, co-operation and continuity are all-important.

5 The breadth and depth of rehabilitation is such that many clinicians may experience difficulty in assessing needs, particularly when these do not apparently have any significant clinical impact, or when solution is outwith their professional competence or understanding. When this occurs, unless supporting disciplines or more expert skills are called into play, the definition, supervision and implementation of a planned programme of rehabilitation may be impossible.

6 As a subject, rehabilitation embraces many disciplines and interests. Within certain specialities, such as geriatrics and psychiatry, and in the management of certain disabling conditions such as paraplegia, the need for the establishment of comprehensive and effective rehabilitation services has been largely recognised. Certain groups of patients, such as those with head injuries, present complex problems, whose solution requires study in depth. The relationship of social work services and techniques of industrial and social rehabilitation to health services present a wide field for study. Because of the range of rehabilitation services, we thought it essential to concentrate on what was considered the central issue—the mechanism whereby leadership, co-ordination and direction of the process of rehabilitation can be achieved.

7 Because of this, the report dwells in some detail on this issue, and it is accepted that in the vast field of rehabilitation, there are many areas which have been examined less intensively than we would have wished, had time permitted. While this approach may disappoint the enthusiasts working in particular fields of rehabilitation, the service will never gain the purpose and momentum which it so urgently requires unless these qualities can be effectively developed as the central driving force of the system.

8 Because of the somewhat radical nature of our principal recommendations, we foresee a need for gradual development, for experimentation and for continuous review of the service. Nothing could be more undesirable than to replace the inactivity of the past twenty years with an outburst of misguided and over-hasty action.

9 A Sub-Committee, with similar terms of reference, under the chairmanship of Professor Sir Ronald Tunbridge, has been examining rehabilitation services in England and Wales during the same period. Reciprocal visits have been paid by the Chairman and Secretaries. We are greatly indebted to Professor Tunbridge and his colleagues for the valuable exchanges which took place, and for the readiness with which they made available to us evidence from a number of organisations, in order to avoid duplication of effort. Although the two Sub-Committees adopted different approaches to their remit, and notwithstanding the different professional and historical

background to rehabilitation services in the countries concerned. it is noteworthy that many of the problems encountered were broadly similar.

10 Furthermore, a Committee on the Remedial Professions, also under the chairmanship of Professor Tunbridge, has been considering 'the function and inter-relationship of occupational therapists, physiotherapists and remedial gymnasts in the National Health Service, their relation to other personnel concerned with rehabilitation, and the broad pattern of staffing required.'

11 It might be thought that, because of this, the constitution of a separate committee to examine rehabilitation services in Scotland was unnecessary. There are, however, certain fundamental points of contrast in the present pattern of services. In Scotland, Physical Medicine has not developed to the same extent as a specialty, and it is fair to say that its scope is generally regarded by the medical profession as being limited. In consequence, in most parts of the country, there has been no focal point around which rehabilitation services could be developed. By the same token, there is no historical framework upon which proposals for change and development have to rest. While the lack of development of rehabilitation services in Scotland in the past is to be deplored, it affords a rarely found opportunity for introducing positive and far-reaching proposals, unfettered by tradition or expedience.

12 In addition, Scotland has a total population which is equivalent only to that of a large Regional Hospital Board in England, and it is spread over a geographical area equivalent to half that of England and Wales. There is a different pattern of organisation of health services. Hospitals tend to be smaller in size, and the teaching hospitals exercise a rather different function from their English counterparts, in that they have always fulfilled the role of a district hospital. The Social Work (Scotland) Act of 1968 introduced important changes in the organisation of social work services in advance of similar changes in England and Wales.

13 Towards the end of our deliberations, evidence was invited from a number of organisations and individuals. The response was remarkable, and many clearly devoted a lot of time and effort to the preparation of their evidence. The Sub-Committee was greatly encouraged by their obvious interest and concern, and wishes to record its appreciation of their assistance, and to acknowledge the value of the information received, all of which added weight to its own assessment of the needs of the situation. A list of those giving evidence is given in Appendix I.

14 Oral evidence was received from representatives of the Department of Employment and the Social Work Services Group. This evidence did much to highlight areas of common concern and identify various difficulties and problems, and it would be of value if corresponding discussions were to take place at an early date at local level. We also took the opportunity to question various individuals whom we met in the course of our visits to various units, and we are indebted to them.

15 In 1970, a group of members were privileged to visit rehabilitation centres in certain European countries. The information gleaned from this visit was invaluable, and we were greatly impressed both by the advances in rehabilitation services, and by the apparent evidence of widespread social concern for the disabled in those countries. The lessons of that visit have influenced the content of this report, and we are deeply grateful to all whom we met, for sacrificing so much of their time on our behalf. References are made from time to time in the report to services abroad, and a full report of our visit is reproduced in Appendix II.

General Summary

1 Our general conclusions and recommendations have been summarised at the end of appropriate chapters in the report, but we think it will be helpful to bring together our principal conclusions in narrative form. The following paragraphs have been produced with this objective in view. For convenience, we have also summarised in paragraph 13 the main recommendations made in the report.

2 Our examination of the complex subject of rehabilitation in the health service revealed its interdependence with so many other official and voluntary services that we were unable to encompass in detail all its many facets and implications.

3 We were not surprised at the absence of conclusive statistical evidence of the advantages which would accrue to individuals or to society from the development of a more determined rehabilitation programme. Such evidence is absent in regard to any specialty of similar complexity. The need is amply demonstrated, however, by various studies of the prevalence of handicap and the incomplete 'social rehabilitation' of many patients finding their way back into the community from hospital.

4 Our criticism of the present service is that because of lack of co-ordination, effort, interest, understanding, definition and knowledge, the facilities provided are patchy and often seriously deficient or absent. Considerable developments have taken place in many situations of obvious need, such as the geriatric and psychiatric services, where the basic principles of medical and social rehabilitation are now widely recognised and practised. Many special centres combining highly sophisticated therapeutic and rehabilitation services have been established for the management of patients suffering from the effects of trauma or disease. Much has been done, also, in the development of aids to assist the disabled. On the other hand, large areas of need remain unrecognised and unsatisfied because of the lack of a dynamic and objective approach on the part of the clinician to the idea that the object of treatment is not only the maximum recovery of function as quickly as possible, but also restoration of the individual to the fullest mental, physical and social usefulness of which he is capable. Usually the clinician is satisfied with the arrest of the disabling process without regard to its consequences in terms of industrial and social adaptation.

5 The need is to extend the excellent work which is presently being carried out in some situations to the whole range of medical care. If this need is to

be satisfied, it will involve the redeployment of some services, the development of others and the creation of a new framework within which these advances can be achieved.

6 To achieve this the creation of a specialty of Medical Rehabilitation and its recognition as an equal partner with other disciplines in clinical medicine is required, if the practices involved are to permeate the medical care system and become a dynamic component of clinical practice.

7 In keeping with the creation of the new specialty of Medical Rehabilitation is our recommendation about the establishment of specialist posts in medical rehabilitation. While we are impressed by the achievements of the many clinicians in various disciplines who at present provide excellent rehabilitation services, our recommendation is designed to extend this activity throughout the whole system of medical care. These proposals need not usurp or erode these areas where rehabilitation is already practised with such effect.

8 We believe that these new posts should have a management as well as a clinical content and our recommendations deal in some detail with the characteristics and with the qualifications of those who should be regarded as eligible to fill them.

9 The promotion of this new discipline must take account of the availability of suitably trained personnel to assume the dynamic leadership which is necessary to give it impetus. The recruitment and training of young doctors of ability, enthusiasm and dedication is required to enable future expansion to take place. Thus our recommendations call for the establishment of medical rehabilitation departments in all the Scottish teaching hospitals as the first phase of what will eventually become a nationwide service. In the first place, such appointments should be clinical and within the National Health Service. We believe it important that similar whole time appointments should be established at the same time within University Medical Schools, and that initially at least one of these might aspire to professorial status.

10 We concluded that the maximum need was to identify the new specialty and to provide it with the necessary structure and impetus. We would expect this to be accompanied by a demand for the development of more resources in the field, with a view to obviating unnecessary utilisation of hospital facilities by providing suitable treatment at the ambulatory care level. In this respect, we welcome the recognition of the primary medical care system and the development of health centres, which offers a unique opportunity to provide a comprehensive medical rehabilitation service. While it is recognised that many general practitioners may not have the opportunity to practice from a health centre for some years, their collaboration, whether as a member of the specialist team or in a more general way, is regarded as an essential element in this service.

11 The trend towards the establishment of day hospitals also offers an opportunity to extend the work of the rehabilitation services more widely throughout the community.

12 While the range of activity involved in medical rehabilitation extends far beyond the matters discussed in this report, we are confident that those responsible for the planning and execution of our recommendations will have achieved the necessary base for development if they implement these recommendations quickly. A further re-examination of the whole subject should take place within five years so that the pace of development can be maintained.

13 Summary of Principal Recommendations

(i) Medical Rehabilitation should be recognised as a specialty in its own right, and a limited number of consultant appointments made in teaching hospitals (*Chapter 5*).

(ii) Appropriate training arrangements in Medical Rehabilitation should be formulated to provide for future expansion of the specialty (*Chapter 7*).

(iii) Consideration should be given to the establishment of arrangements both at national and regional level, to review and advise on the co-ordination of all rehabilitation services (*Chapter 7*).

(iv) The academic aspects of Medical Rehabilitation must be developed, and to achieve this, Senior Lecturers in each of the four medical schools might be appointed. Ultimately there should be established separate Departments of Rehabilitation with a professorial head (*Chapter 8*).

(v) The need for the development of undergraduate teaching in rehabilitation should be drawn to the attention of the appropriate authorities (*Chapter 8*).

(vi) There is a need for research into all aspects of rehabilitation services (*Chapter 8*).

(vii) Steps should be taken to increase recruitment to the remedial professions and to recognise their contribution towards the provision of a comprehensive rehabilitation service (*Chapter 9*).

(viii) In the planning of rehabilitation services, special attention should be paid to the provision of suitable accommodation, including day hospital facilities (*Chapter 10*).

(ix) Special steps should be taken to review the needs of the mental health services in each area so that the role of the various authorities involved can be more precisely defined (*Chapter 10*).

(x) Information services about aids and appliances should be improved; their methods of prescription and renewal should be simplified; and consideration should be given to the establishment of a central organisation to co-ordinate and evaluate all the development work undertaken on aids and appliances (*Chapter 11*).

(xi) Voluntary organisations have an important role in the provision of a comprehensive rehabilitation service, and in developing their activities, they must work more closely together and in association with statutory authorities (*Chapter 12*).

1 Existing Services

1.1 The provision of rehabilitation services is undertaken by many different agencies, including hospital authorities, local health and education authorities, the Department of Employment, Social Work Departments, and voluntary organisations. The general practitioner, with his intimate knowledge of the clinical and social background of his patients, has a key role to play. Apart from the patient himself, many individuals may be involved—relatives, nurses, doctors, educationalists, social workers, therapists, disablement resettlement officers and employers. Relevant legislation embraces a wide field of social concern. (Appendix III).

It is not our intention in this chapter to describe in detail all the multiplicity of roles and functions of these various agencies, or to outline the general provisions of a series of Acts of Parliament, but to indicate the salient features of the development of rehabilitation services, and to sketch in, briefly, the services provided by different authorities.

1.2 The Development of Rehabilitation Services

The early development of rehabilitation services can be traced to the influence of the First World War, which brought in its train a need to diminish the loss of manpower caused by injury and inadequate after-care. Although the value of a comprehensive rehabilitation service was largely forgotten in the period between 1918 and 1939, the Second World War, which resulted in the introduction of the Emergency Medical Service and the establishment of centres for the treatment of service casualties, re-established the foundation of an organised rehabilitation service. This was reinforced by legislation based largely on the Tomlinson Report of 1943 (Cmnd 6415)[1], and providing a variety of medical and social services. One feature of this report was the creation of a dichotomy between 'medical' and 'post-hospital' rehabilitation, and the separation of overall responsibility for the provision of rehabilitation services between two Government Departments. This separation persists to the present time, in that the Scottish Home and Health Department are responsible for medical rehabilitation services, and the Department of Employment are responsible for industrial rehabilitation services. The following paragraphs describe, in general terms, the nature of the services provided by the different agencies.

[1] *Report of the Inter-Departmental Committee on the Rehabilitation and Resettlement of Disabled Persons*, HMSO 1943 – Cmnd 6415

1.3 Health Services

Hospital and Specialist Services

The development of hospital and specialist rehabilitation services in Scotland could be described as uneven and disjointed, although there are signs of a more coherent pattern emerging. To a widely varying extent, most general hospitals have for some time recognised an obligation to promote the 'fitness' of their patients for return to normal living. This obligation may be expressed in ways ranging from general advice on convalescence and return to work, through to a planned programme designed not only to restore maximum function following disease or injury, but also to mobilise the services which bear on the welfare of the 'whole' man. Some hospitals have grouped the various technical medical services into a special department or centre, and new departments of this type have been recently provided at the Southern General Hospital, Glasgow, and at Raigmore Hospital, Inverness. In most hospitals, physiotherapy and occupational therapy departments have been provided or extended. Certain regional boards have special rehabilitation units or hospitals, such as the Rehabilitation Unit at Bridge of Earn Hospital, and the Medical Rehabilitation Unit at Uddingston. The Astley Ainslie Hospital in Edinburgh has developed and extended its function from a convalescent hospital to include rehabilitation functions. Some specialised units throughout the country have developed their rehabilitation function in conjunction with their treatment and research activities, such as the Rheumatic Diseases Unit in Edinburgh, the prosthetic centres in Dundee and Edinburgh, and the spinal injuries units in Edenhall Hospital, Musselburgh, and in Philipshill Hospital, Glasgow.

1.4 Such developments as there are have taken place through the energy, initiative and special interest of individuals. The general development of services, however, has been hampered by the lack of consultant appointments. There are only six consultants whose main commitment is rehabilitation. Two of these are very recent appointments, and it is generally difficult to attract supporting staff. The existence of these appointments seems to owe more to historical accident than to planned overall development of the service, and in many cases their relationship with colleagues in other specialties is ill-defined. By and large, rehabilitation is seen as part of the responsibility of each hospital consultant who makes use of supporting facilities in the hospital and the community according to his assessment of his patients' needs, and to his interest in and knowledge of these facilities.

1.5 Hospital authorities have a responsibility to provide certain medical and surgical appliances such as invalid chairs, surgical footwear, artificial limbs and walking aids. These can be issued only on authorisation by a consultant.

1.6 Resettlement Clinics

For patients presenting special problems, 'resettlement clinics' have been established in some hospitals. These are clinics at which are present the consultant in charge of the patient, the general practitioner, the physiotherapist, occupational therapist, social worker, and the disablement resettlement officer, and at which the patient's capacity and limitations can

be fully assessed. Such clinics have been established in various centres in Scotland. Few in number, and varying in their modus operandi, their influence has been indeterminate, and although they have proved that with skill and enthusiasm they can be of value, there has been little evidence, either on the part of hospital authorities or individual clinicians, of desire to expand and develop these clinics.

1.7 Paediatric Assessment Clinics

One recent development of which we learnt with interest is the establishment of paediatric assessment clinics, on the pattern recommended in the Sheldon Report[2]. A centre for this purpose is being provided at the Royal Hospital for Sick Children in Glasgow with the help of the Fraser Foundation. Under the direction of one person, either a consultant paediatrician or a paediatric neurologist, and staffed by a multi-discipline team, which includes, for example, a child psychiatrist, an orthopaedic surgeon, a school medical officer, clinical psychologist, social worker and health visitor, these clinics will provide a locus for the concentration of skills required for comprehensive assessment of the child with multiple handicap. Such children are particularly vulnerable when passing from the care of one specialist to another, from one age group to another, or from one hospital to another. Their parents may have no clear source of advice or encouragement. Notwithstanding the demands such patients make on individual services, the efficiency of their management may be less than desirable because no one person is responsible for the whole child. Comprehensive assessment clinics afford the opportunity to overcome these difficulties, and to ensure that the processes of transition are as smooth and continuous as possible. Their establishment is one of the few encouraging features in an otherwise rather depressing landscape.

1.8 Psychiatric and Geriatric Services

In marked contrast to the picture in the acute general hospitals, there has been considerable activity in the field of geriatrics and psychiatry. Psychiatric services have been subjected to radical change during the last 20 years. Out-patient treatment and/or short term hospitalisation is now the most common outcome of referral. In the long-term wards the custodial and repressive attitides of the more distant past have been replaced by encouragement towards increasing contact with the community, even when complete discharge from hospital is not possible. Psychiatric patients are often accommodated in general hospitals or special short-term units, and psychiatrists are available for consultation in all district general hospitals. The Consultant Psychiatrist deals extensively with patients with stress reactions and with personality disorders.

1.9 Severe psychiatric illness results in dislocation from work and disruption of the individual's social pattern. In such circumstances, rehabilitation procedures are an essential part of treatment, even when response to drugs is a major therapeutic factor. In this situation, psychiatric hospital work

[2] *Report of the Working Party on Comprehensive Assessment Centres for Handicapped Children 1968*

incorporates and demonstrates rehabilitation principles — the importance of individual problems of adaptation coupled with consideration of environmental situations and their modification. Such measures have as their objectives the maintenance of the highest personal and social level of function of which the individual is capable.

1.10 The need for work with families and community support was recognised by the statutory designation of responsibility for aftercare to Local Authorities, previously through the Health Department, and now by the Social Work Department, which has also extensive responsibility for the care and training of mentally handicapped people. The specially trained psychiatric social worker and mental health officer, now absorbed into the general body of the social work profession, expressed this need. The current state of development of the Social Work Departments, however, creates a situation in which functional relationships between hospital and local authority staff are sometimes not clear. This may have the advantage of offering scope for experiment.

1.11 Within psychiatric hospitals, day patient care is an accepted routine and arrangements are frequently made whereby patients occupy hostel accommodation in the hospital so that they can continue to have support during the critical period of returning to work before the completion of treatment. Simple factory-type work is frequently brought into hospital to provide therapeutic occupation. This type of 'industrial therapy' is used extensively for long-term patients, and to a lesser extent with the short-term. Various types of self-care are encouraged, including hostel wards and group homes. Local Authorities have the power, unfortunately little used so far in Scotland, to provide hostel accommodation. Some hospitals use nursing staff to help in supporting patients in the community when the nurses' special skill is particularly appropriate. A survey undertaken during the period of the Committee's deliberations showed that the need for the procedures described above was accepted throughout the psychiatric services and that many requests for increased and improved facilities are currently under consideration by Regional Hospital Boards.

1.12 A very similar pattern can be traced in the field of geriatrics, where there is emphasis on active rehabilitation following comprehensive assessment on the mobilisation of community resources, on day care, and on long term follow-up and support. In all regions, there are very active geriatric rehabilitation units, and accommodation and facilities are being expanded. Both in geriatrics and psychiatry, rehabilitation is seen as an integral aspect of medical care.

1.13 General Medical Services

The main concern of a general practitioner is with the treatment of patients who do not require admission to hospital, but he is responsible also for the treatment of patients after discharge from hospital. The essence of the care he provides can be summarised as primary, personal, continuous, comprehensive and family-orientated. The general practitioner manages the

care of the vast majority of patients with chronic ill-health and disability, and is the link between the patient and the variety of services, statutory and voluntary, which can be called into play in support of the patient. One responsibility of the general practitioner is the issue of a limited range of appliances. General practitioners occupy a key position from which they can exercise a profound influence on the after care of patients discharged from hospital.

1.14 Local Health Authority Services

The Social Work (Scotland) Act 1968 transferred to Social Work Departments of local authorities many of the functions which were formerly the responsibility of local health authorities, and the impending reorganisation of health services will provide for further transfer of services from local health authorities to health boards.[3]

At present, however, local health authorities can and do contribute to rehabilitation services. Through the Medical Officer of Health, they are responsible for home nursing and health visitor services. They are responsible for school health services, and for child welfare clinics, and in the exercise of these latter functions can do much to assist the progress of the handicapped child.

As medical adviser to the local authority, the Medical Officer of Health may be involved in questions of re-housing, which is often of vital importance to the success of a rehabilitation programme. He may become directly involved in questions of employment because of the need for liaison between the School Health Service and Youth Employment Services.

1.15 Education Services

In order to reduce interruption to the education of sick and handicapped children, classes are established in hospitals providing services for long-stay children, and if necessary, after assessment arrangements can be made for individual tuition either in hospital or at home. Day and residential special schools are available for handicapped children who, by reason of handicap, are unable to attend ordinary schools. Local education authorities have recently been made responsible for education services in hospitals for the mentally retarded. In addition, further education facilities are provided for adults including courses, classes and lectures, and, in certain hospitals, correspondence courses and textbooks.

1.16 Social Work Services

Under the Social Work (Scotland) Act 1968, local authorities have established Departments of Social Work. These Departments are now responsible for the services previously undertaken by the welfare, child care, and probation services, and for some of the social work services formerly provided by the Health Department of the Local Authority. The reorganised services include the care of children taken into care, the welfare of the elderly and the physically disabled, and the support of the mentally handicapped. The Departments

[3] *Reorganisation of the Scottish Health Services* HMSO Cmnd 4734

have a general duty to promote social welfare by providing guidance, assistance and advice, and by providing facilities such as residential and other accommodation. This includes old people's homes, centres for the handicapped, day care centres for mentally handicapped children, and occupation centres and hostels for mentally handicapped adults. Domiciliary services for which they are responsible include the home help service, and the provision of special aids and appliances, and works of adaptation such as ramps, door widening, handrails, etc.

1.17 The new organisation provides local authorities with a unified social welfare service, which can draw on any of the social work resources required by the individual or his family. Despite generous increases in the financial allocation provided for their work, the Social Work Departments have been hampered by previous deficiencies of staff and other resources. It may be that the services they can provide will for some years be less comprehensive and efficient than is desirable. Nonetheless, the new arrangements while highlighting problems of understanding, organisation and co-ordination, also offer the opportunity of adding to the health care system the support of a comprehensive community social work service and the prospect of mutual, wide-ranging involvement in the promotion of health and in the medico-social aspects of disease.

1.18 The Department of Employment

In the course of our discussions, it emerged that many members of hospital staff, general practitioners and other workers in the field of rehabilitation were not familiar with the services provided by the Department of Employment. For this reason, there is included an appendix dealing in some length with the Industrial Rehabilitation service (Appendix IV). The following paragraphs will, however, serve for general guidance at this stage.

1.19 The services provided by the Department of Employment for the disabled consist of:

(a) A specialist placement service operated by Disablement Resettlement Officers.

(b) Courses of industrial rehabilitation provided at Industrial Rehabilitation Units.

(c) Courses of vocational training provided at Government Training Centres and Residential Training Colleges.

(d) Voluntary registration of disabled persons, with which is related the quota system, and the provision of sheltered and designated employment.

1.20 Disablement Resettlement Officers

Important changes have recently been introduced by the Department of Employment in the organisation and training of the Disablement Resettlement Officer service, which is now based on areas, rather than on individual employment exchanges. Almost all part-time Disablement Resettlement Officer posts have been eliminated, and replaced by peripatetic full-time

Disablement Resettlement Officers engaged exclusively on resettlement duties. Where there are several Disablement Resettlement Officers in an area, one of the assistant managers in the area office has an identifiable functional involvement in the service, and is known as a Senior Disablement Resettlement Officer. The maintenance of links between local and regional officers has been preserved by the appointment of Regional Disablement Resettlement Officers (on the Senior grade) whose functions are to co-ordinate Disablement Resettlement Officer work in the field and thus maintain the quality of the service. He also has special responsibility for training, for hospital liaison arrangements, and acts as a source of expert advice for Disablement Resettlement Officers.

1.21 These changes have several advantages. Every disabled person now has access to a full-time specialist placement officer. The quality of service provided is improved, because of concentration of expertise and improved training. The provision of a career structure for Disablement Resettlement Officers should improve the calibre of persons selected for these posts. Their areas of responsibility are small enough to allow them to gain knowledge of their clients and the range of local employment opportunities.

1.22 Industrial Rehabilitation Units

The aim of courses at Industrial Rehabilitation Units is to assess aptitudes and abilities, to restore the maximum degree of fitness for employment in people whose physical or mental capacity has declined through sickness or injury, to help them regain confidence in their ability to obtain and retain employment, and to adapt themselves mentally and physically to working under ordinary industrial conditions, or, in some cases, sheltered employment. Industrial Rehabilitation Units are managed by a rehabilitation officer, who is supported by a part-time medical officer, usually a general practitioner employed on a sessional basis, by an industrial psychologist, social worker, occupational supervisors, etc. The staff form a team for the purposes of assessing new patients on admission, during rehabilitation, and prior to discharge. Each person is given an individually planned course, based on initial assessment.

1.23 Regional Medical Consultants

Since the passing of the Disabled Persons Employment Act 1944, there have been Regional Medical Advisers, now termed Regional Medical Consultants, at Regional Offices of the Department of Employment. In Scotland, this officer is appointed by and seconded from the Scottish Home and Health Department. The present range of duties of a Regional Medical Consultant is:

(1) To assist in developing the fullest co-operation within the Region between the employment services of the Department and the hospital and other medical services and the medical profession generally, in regard to the problem of placing disabled persons in particular, and in regard to the recruitment of persons who would benefit from a course of industrial rehabilitation from hospitals and general practitioners.

(2) To advise the Regional Controller on the organisation and conduct of medical services in Industrial Rehabilitation Units and Vocational Training Centres.

(3) By association with the appropriate Departments of Universities or approved hospitals or in other ways, to maintain a research and teaching interest in the industrial rehabilitation and resettlement of mentally and physically disabled persons.

1.24 Regional Medical Service

The service is responsible for the medical examination of persons referred mainly by several government departments because a second opinion is required either on the individual's fitness for his normal work or his fitness to engage in some kind of alternative employment. References are also initiated by general practitioners for such opinions.
In Scotland the Service is based on 5 areas with headquarters in Glasgow, Edinburgh, Dundee, Aberdeen and Inverness where the 15 full time Regional Medical Officers are stationed. In addition to the full time staff, who are employed by the Scottish Home and Health Department, there are 78 part-time medical examining officers who carry out about 60 per cent of the examinations. These doctors, with only a few exceptions, have experience of general practice and most are currently in active practice. The Service is co-ordinated by the Scottish Home and Health Department in Edinburgh. Most of the persons considered by the Regional Medical Officer to be in need of rehabilitation have been referred by the Department of Health and Social Security.

1.25 When a patient is found unfit for his usual employment as a result of such an examination, the regional medical officer considers whether or not admission to an Industrial Rehabilitation Unit would be helpful in restoring the patient's working capacity. Alternatively he may advise that the patient is fit for alternative or lighter employment with or without a period of rehabilitation. Analysis of the outcome of recommendations for admission to an Industrial Rehabilitation Unit show, however, that only a small proportion subsequently attend.
Recommendations for rehabilitation by the Regional Medical Officer in this group of patients is made after a fairly rapid assessment in the course of examining a largely unselected group of individuals referred by the Department of Health and Social Security and it is not possible for the Regional Medical Officer to pre-select those cases which might benefit from a more leisurely assessment. This is done, however, in the group of cases referred by the Department of Employment in connection with determining the individual's suitability for admission to the Disabled Persons Register.

1.26 In addition to his clinical function, the regional medical officer regularly visits family doctors in his region and so provides a link between the Scottish Home and Health Department and the individual general practitioner.

1.27 Voluntary Organisations

Voluntary Organisations have always played an important part in the provision of services for the disabled, and notwithstanding increasing statutory provision, have continued to be in the forefront, pioneering new services, making known to the central authorities emergent needs, often in a most articulate and effective manner, pressing for improved statutory provision for the handicapped, and unobtrusively yet effectively reinforcing services in areas of particular need.

1.28 A detailed survey of the work undertaken by voluntary organisations was not made, not because of any doubt of its value, but rather on the assumption that voluntary bodies would continue to be a vital force in the development of rehabilitation services, and that our primary duty was to seek to develop a corresponding initiative within the health care system, and thus help to ensure that statutory and voluntary bodies could work ever more closely together.

2 The Deficiencies in Existing Services

2.1 Rehabilitation may be provided in many different ways, and it would be wrong to suggest that a proper rehabilitation service is never provided. Many doctors take a great interest in rehabilitation, and do their utmost to see that it is carried out effectively. Some specialties are recognisably in advance of others. One of the disturbing features of the present situation is that within a hospital, and even within the same specialty within a hospital, the quality of rehabilitation services can vary enormously.

2.2 Our preliminary opinions on the general inadequacies of rehabilitation services were supported by the evidence submitted to us. What became apparent was that the most serious deficiency was the lack of co-ordination of effort, information, knowledge and facilities. Each of the many agencies involved in rehabilitation seems, in the main, to be working either in relative or total isolation. Although there are contacts between agencies, these are usually tenuous. Only rarely does there occur a positive rapport. Inadequate knowledge of related activities often results in a patchwork of services, in which the benefits accruing from particular treatments or services are dissipated because of the absence of a strong continuing link between them. In the following paragraphs, there are described several of the principal deficiencies in existing services.

2.3 Lack of Interest

Frequently, rehabilitation does not begin early enough. It should begin ideally in the first approach when a patient seeks medical aid. 'Rehabilitation begins at the beginning of all treatment'. All too often, however, it is regarded by the doctor in a restricted physical sense, something which may or may not be applied when 'real' treatment is nearly over. Many doctors ignore the fact that confinement to bed for any length of time, from whatever cause, leads to a significant deterioration in physical fitness, irrespective of the deleterious effects of illness or injury. Failure to restore a reasonable degree of fitness before discharge from hospital care often results in unnecessarily prolonged periods of absence from work.

Essentially this is a problem of education. It was suggested to us that in medical education there was still a tendency to restrict instruction to diagnosis of disease rather than to its management. From the evidence we received from the undergraduate Deans of the four medical schools, it appeared that rehabilitation instruction was minimal, and that the emphasis of undergraduate medical education was rarely directed towards teaching the student to see the patient as a 'whole man'.

2.4 Lack of Knowledge

There is evidence of a general lack of knowledge of the potential of a planned rehabilitation programme and of the services which form an integral part of this programme. All too often rehabilitation is seen simply as the clinical resolution of some physical disability, without any consideration of the mental attitude, social condition or educational status of the patient. Many doctors working in hospital are so involved with the application of highly complicated techniques both for diagnosis and treatment, that they find it difficult to visualise their patients in a setting outwith the hospital. So far, too few doctors in clinical practice have had the opportunity to benefit from instruction or experience in active rehabilitation techniques. There is a general lack of knowledge of the services provided by the Department of Employment and other rehabilitation agencies. Increasing understanding and knowledge of these services on the part of health service personnel would be of mutual benefit. Few nurses and medical students are aware of what happens in a physiotherapy or occupational therapy department and the benefits derived from this and other forms of rehabilitation. Some social workers base after care services on an assessment of priorities which does not adequately take medical criteria into account.

2.5 These are but a few examples of lack of knowledge of the rehabilitation process. This is not confined to any particular discipline, or profession. The medical profession have a particular responsibility, however, to take the initiative in creating a strong, efficient and purposeful organisation in which teamwork can play its part in delivering an effective service.

2.6 Lack of Co-ordination and Communication

The rehabilitation team requires participation by many types and grades of people. Doctors, nurses, physiotherapists, occupational therapists, social workers, employers, disablement resettlement officers and others in contact with people who have been ill or injured have an individual contribution to make. This may be achieved by showing understanding and encouragement, by accurate assessment of working capacity, or by modification of working conditions. Any or all of these people can help in the rehabilitation of those in need, thus exemplifying the principle that rehabilitation may depend upon an attitude of mind rather than a complex of techniques.

2.7 Within the hospital the team approach is by no means universally adopted, and para-medical and social work staff often have to work in ignorance of the total needs of the patient.

There is often a fundamental problem of communication between patients and doctors. Communication on many aspects of rehabilitation and resettlement between the hospital and the general practitioner is often inadequate, and all too often the latter is prevented from exercising a more positive role by inadequate information about these matters in hospital discharge letters, or by the assumed need for continued follow-up at hospital. The process of change brought about by the Social Work (Scotland) Act 1968 has heightened the awareness of problems of liaison on all sides. Communication between the Department of Employment services, and all branches of the health service is varied, and frequently poor.

What is most often conspicuously lacking is a co-ordinated plan for each disabled person. The greatest single need at present is for an organised rehabilitation service which will identify patients at an early stage, draw up a plan which combines both medical, social, educational and occupational phases of rehabilitation, and which is linked to resettlement.

2.8 Lack of Research

Research studies into the effectiveness of rehabilitation are limited in number. In areas where these services have been available for some time, even if only in simple form, there has been little effective research to produce evidence of the positive effect of planned rehabilitation. The absence of such evidence has hindered the development of rehabilitation services.

2.9 Staffing

Central to the problem of development of any service is the question of staffing, and on this we received conflicting evidence. Staffing questions relate both to medical staff and to other workers. Since the considerations affecting each are different, they are best examined separately.

2.10 Medical Staffing

We have already referred to the paucity of consultants working in the field of rehabilitation within the health service. Industrial Rehabilitation Units are staffed mainly by general practitioners with part-time sessional contracts. In addition, however, there are a number of doctors working in the field of occupational health, either in industry, or in academic departments. While there is no doubt that there is a need for additional medical staff in rehabilitation services, assessment of that need is complicated by the separate development of these services.

2.11 We were concerned to note that no Regional Hospital Board appeared to have any proposals for the appointment of additional medical staff for rehabilitation. In addition, the Department of Employment appeared to be reasonably satisfied with their present medical arrangements for staffing Industrial Rehabilitation Units. We have been encouraged, however, to learn of the staffing arrangements at Bellshill Industrial Rehabilitation Unit, whereby the doctor concerned also has duties in the Medical Rehabilitation Unit at Uddingston run by the Western Regional Hospital Board. In addition, the Eastern Regional Hospital Board and the Department of Employment have recently agreed to introduce an experimental arrangement whereby medical cover of the new Industrial Rehabilitation Unit in Dundee will be provided by a doctor appointed by the Regional Board, who will also have duties in hospital rehabilitation services. These are bold and imaginative steps forward, and it is to be hoped not only that they will achieve the success they deserve, but also that other Boards will consider similar arrangements. It should, nonetheless, be pointed out that such joint staffing arrangements were recommended in the Piercy Report of 1956.[4]

[4] *The Rehabilitation Training and Resettlement of Disabled Persons* HMSO 1956 (Cmnd 9883)

2.12 Adequate medical staffing of rehabilitation services is an essential pre-requisite to any further development, and unless and until this is achieved. no useful advances can be expected.

2.13 Para-Medical and Other Staff

In the evidence we received, there were innumerable pleas for additional staff of all types, and in some cases it was suggested that this was all that was required to provide an effective service. Staffing trends show, however, that there has been a continuing increase in all categories of personnel, with the exception of remedial gymnasts.

2.14 Physiotherapists, occupational therapists, social workers, speech therapists and remedial gymnasts can be employed by different bodies, such as Social Work Departments, hospital Boards of Management, local health authorities or voluntary organisations. There is no evidence of a co-ordinated staffing plan in any area. Each organisation recruits as best it can, even if this is at the expense of other organisations in the same area.

2.15 One point which was repeatedly raised in evidence was that para-medical staff seemed to be in short supply because proper use was not made of their skills. This may be true, since medical staff are not taught how to use the remedial departments of a hospital, and few hospital staff have any knowledge of the services which may be available in the community.

2.16 The Use of the Remedial Departments

We have already commented on the fact that staffing requirements may be affected through improper use, due to lack of knowledge, of the remedial departments in a hospital. Development of these departments seems to have been affected by the absence of any mechanism whereby their legitimate demands can be presented to management. If staff are in short supply, there should be one person responsible for the organisation of these services, to ensure that proper use is made of the facilities available. Staff in these departments need a ready source of medical advice and guidance in the day-to-day running of the service. Although the majority of treatments are simple and uncomplicated, there are many occasions when positive clinical support and advice is essential.

2.17 Accommodation

Although many extensions and adaptations have been made to physiotherapy and occupational therapy departments, and although some new centres have been built with modern facilities in an attempt to provide comprehensive departments of rehabilitation, there are few departments in hospitals where patients can have intensive daily rehabilitation, with the necessary supporting facilities. This lack of accommodation leads to fragmentation and lack of co-ordination of staff resources. Even in the newest departments there is no dining accommodation for patients, and in no case have hostel beds been made available, even on an experimental basis. Day hospital provision is the

most likely form of development in the future and more hospitals should provide facilities for this. There have been few experiments in the use of minimal care beds in hospital, despite substantial evidence of their potential value.[5] Some general practitioners practise from unsuitable and inadequate accommodation, although this is now being remedied by the extensive building programme for health centres. Local authorities in Scotland have made little use of their powers to provide after-care accommodation.

2.18 Aids and Appliances

Aids and appliances can be supplied to patients from more than one agency. While it may be thought that a 'blunderbuss' approach to this question helps to ensure that the needs of most are met in one way or another, the evidence we received suggested that, on the contrary, it lends to confusion as to whose responsibility it is to supply these items. A majority of staff of the health service, including medical staff, have an inadequate knowledge of what aids can be supplied, where they can be obtained and what their limitations are. It is our view that there is a need for co-ordination of the information available about aids and appliances, for clarification of the functions of different agencies in this field, for a planned research and development programme, and also for simplification of the arrangements for their provision. These views are developed in Chapter 11.

2.19 General Conclusions

Apart from a few examples of progress in specialised fields, there is little evidence of purposeful activity in developing rehabilitation services, or in stimulating new and imaginative patterns of care. All of the factors outlined in the preceding paragraphs have adversely influenced both the adequacy of rehabilitation services and their further development. Each must be remedied in some way if rehabilitation services are to be improved. We have no doubt, however, that the essential need is for medical leadership of the rehabilitation process. At the present time young doctors are understandably reluctant to develop an interest in a field about which they are taught little, for which little is done, which their seniors patently neglect, and which appears to lack the necessary passwords to clinical respectability.

2.20 The relative importance of other deficiencies will recede if medical leadership is provided. Positive direction of the service will improve knowledge, communications, the use of staff, co-ordination of staff, and research and development. Unless this deficiency can be made good, we consider that there can be no worthwhile development of rehabilitation services.

2.21 Services in Other Countries

Having reviewed the main points of criticism of services in Scotland, it is perhaps appropriate to describe the principal areas in which some of the services abroad, as seen in our visit to Europe, seemed to be in advance of

[5] *Hostels in Hospitals.* Oxford Univ. Press for NPHT 1968

those in Scotland. A detailed report on the impressions of the visiting group is contained in Appendix II.

2.22 In all the countries we visited, firm steps have been taken to establish medical rehabilitation as a specialty in its own right. Several countries have imaginative plans for staffing developments in rehabilitation. In Norway and France, we were particularly impressed by the deep involvement of medical rehabilitation staff in industrial rehabilitation, to the advantage alike of the hospital service, the agencies responsible for industrial rehabilitation, and the patient.

2.23 It would be unwise to comment in depth on staffing levels simply on the basis of a cursory visit, without closer analysis of the many factors involved. Our general impression was that on the whole there were available to rehabilitation services a substantial number of supporting staff.

2.24 The question of aids and appliances is examined in detail in Chapter 11, but we were impressed by arrangements in Sweden, where there is published a national catalogue of approved aids and appliances. This is based on applied research and development carried out by one central body which involves users in its research programme.

2.25 In all the countries we visited, there was an impression of a more widespread public concern for the disabled, as evidenced in legislation, the provision of public facilities for the handicapped, such as housing, motor vehicles, etc., and an identifiable central government organisation responsible for rehabilitation services.

2.26 Although the organisation of health and social services in every country visited was complex, there seemed to be a great willingness to experiment in new approaches, and to attempt to involve both statutory and voluntary agencies in concerted effort.

3 The Need for Improvement

3.1 There has been no lack of advice to health authorities and to the medical profession on the need for improvement in rehabilitation services. There has been a constant succession of useful reports on rehabilitation, each of which contains positive recommendations. The central department has issued memoranda to hospital authorities, executive councils and local health authorities. Reports dealing with the treatment and rehabilitation of special groups, such as epileptics, the young chronic sick, and the elderly with mental disorder have been published (Appendix VIII). Occasional bursts of energy and initiative from Regional Boards[6],[7], have been followed by long periods of inactivity. In general, however, there has been little evidence of effective action.

3.2 In addition to the need which can be implied from these earlier reports, there are certain general considerations which suggest that development of rehabilitation services must now be accepted as being of high priority.

3.3 The Changing Pattern of Disease

Many of the fatal diseases of the past have neen largely eliminated in the last hundred years by advances in medical treatment, by environmental measures, and by rising standards of living. There has been a marked change in the age-structure of society, and many more people now live beyond retiral age. Moreover, as a result of these changes, medicine is also faced with outstanding problems in dealing with pre-natal and perinatal morbidity, and with a rising tide of chronic and of degenerative disease, as well as traumatic and acute episodes of illness. Hospital and community care must be increasingly orientated towards the provision of prolonged, co-ordinated medical and social support for the older age-groups in the population, and for the rising number of young people with permanent handicap.

3.4 Technical and Medical Developments

In recent years, substantial progress has been made in the development of highly specialised treatment facilities, such as coronary care, intensive therapy and neo-natal special care units. If the undoubted benefits of these extremely expensive facilities are not to be dissipated, rehabilitation services will become ever more in need of development and improvement.
Furthermore, the rising costs of in-patient care, ever-increasing problems

[6] *Report by Working Party on Rehabilitation,* SERHB 1961
[7] *Review of Rehabilitation Services,* ERHB 1967

of nurse recruitment and staffing, in association with a continuing shortage of all types of medical auxiliaries are further arguments for initiating now an active rehabilitation programme, to permeate the whole medical care system. Not only is a rehabilitation programme an important element in comprehensive medical care, it has also a significant contribution in terms of cost effectiveness. If the emphasis in the past has been placed on technical developments in medicine, these very advances now demand a corresponding development of after-care services. Only if this development takes place will health services be able to contribute to national productivity by restoring persons under medical care to their maximum level of independence, and by enabling people to return to work as soon as possible.

3.5 The Growth of Specialisation

This was admirably summarised in the evidence submitted by the Joint Council on Voluntary Work for the Disabled which said,

> The continued growth of specialisation in medicine has had the unfortunate effect, that while the particular part of a patient may be more effectively treated as time goes on, the patient as a whole is not. The splitting up of the body and mind into relatively self-contained compartments can produce a somewhat myopic view of the problem.
>
> This specialisation has not been confined to the medical profession, and the number of people who are involved in the treatment of the individual case grows each year. There is no doubt that such developments have resulted in the need to train more and more auxiliary workers. This has resulted not only in their numbers increasing, but also in their roles diversifying to such an extent that their efforts may, in a paradoxical manner, unless properly controlled and orientated, delay the recovery of the individual patient.

3.6 The Size of the Problem

The Piercy Report drew attention to the absence of comprehensive data on the number of disabled persons in the community, and on the number of persons who might benefit from rehabilitation. Although the recent completion of the Government Social Survey into the prevalence of disability has remedied the former deficiency, the absence of supporting data has been a problem confronting us throughout our discussions. It is a matter of some concern, and, perhaps, a reflection of general attitudes towards rehabilitation, that there have been few studies undertaken which throw light on this neglected problem. In addition, no evidence could be adduced, either in this country or abroad, of any evaluation studies designed to show the benefits resulting from rehabilitation services. In a time when there is an abundance of research on every aspect of the preventive, curative and operational aspects of medicine, there is a striking absence of activity directed towards the measurement of the benefits obtainable from care in its broadest sense, as depicted by the capacity of patients to live an independent and satisfying life after discharge from hospital. There is some evidence, however, scant though it may be, which lends weight to arguments for the development of rehabilitation services.

3.7 The Nuffield Studies

Probably the most revealing and neglected studies of the effects of hospital care are the Nuffield Studies [8], [9]. Although it is difficult to describe briefly the findings of those studies, and re-reading of these original reports has much to commend it, the following paragraphs summarise the principal points of interest.

3.8 The first report reviewed the social circumstances of over 700 male patients treated in the medical wards of four Scottish hospitals. Only just half of those who were still alive three months after discharge were back at work, and a fifth of these were in unsuitable employment. Two years later 25 per cent had died. Although two-thirds of the survivors were thought to have derived benefit from hospital care, nearly one-third had worked for less than one of the two years since leaving hospital.

3.9 The second report described the results of three studies carried out in Glasgow, Dundee and Aberdeen. The shape of these later studies, while following the broad lines of the original report, was altered to take account of local circumstances and the particular interest of the investigators. These variations make precise comparison difficult, but the broad results of the studies parallel those of the earlier study. Among the factors which emerged from these studies were the need for more effective links between hospital services and the family doctor; for more attention at an early stage in recovery to potential employment difficulties; and for skilled vocational guidance for those patients who seem vulnerable to social and environmental factors. It was suggested that the provision of day or residential rehabilitation centres, aiming at steady restoration from invalidity to reasonable stability of health and working capacity, and closely related both to industrial rehabilitation services and social work services, was urgently required.

3.10 It is disappointing that no similar studies have been undertaken since those early reports. The further development of record linkage, at present in the experimental stage, will present possibilities for original and rewarding research in this field. There are, however, certain other studies which highlight the prevalence of disability, and these are briefly summarised in the following paragraphs.

3.11 The Handicapped and Impaired in Great Britain

This survey, which was carried out by the Social Survey Division of the Office of Population Censuses and Surveys, related to persons aged 16 and over living in the community. It used a wide definition of disability, and it was designed to include all those with minor disturbances of locomotor activity as well as those more severely handicapped. The interview schedule was very comprehensive and covered aspects of the extent of disability, help required with daily care (and with household chores where the subject was also a housewife), services provided and required, mechanical aids, education, training, employment, housing and income. The report produced

[8] *Hospital and Community*, NPHT 1954
[9] *Further Studies in Hospital and Community*, NPHT 1962

a great deal of information; the following tables which have been reproduced by the Research and Intelligence Unit of the Scottish Home and Health Department, show only certain interesting results obtained from the survey.

3.12 Table I shows the estimated numbers in Scotland falling into eight categories of disability and the percentage distribution in each category.

TABLE I Estimated numbers with different degrees of handicap in Scotland

Category	Degree	No.	%
1–3	Very severe	16,000	5.9
4, 5	Severe	35,000	12.7
6	Appreciable	57,000	21.1
7	Minor	56,000	20.7
8	Minor	111,000	40.0

*Source: Table 11 of published report

3.13 Table II shows the overall rate for the disabled for Scotland and for Great Britain. In Scotland 73 persons per thousand aged 16 and over are estimated as disabled on the definition used.

TABLE II Disabled per 1,000 population aged 16 and over

	Men	Women	Men and Women
Scotland	63.1	81.5	72.9
Great Britain	66.7	88.2	78.0

Source: Table 4 of published report

3.14 Table III shows the disease groups accounting for disability and the percentage falling into each group.

It will be noted the Diseases of the Central Nervous System, Diseases of the Circulatory System, Diseases of Bones and Organs of Movement and Diseases of the Respiratory System account for most disability in the community. Appendix V shows comparative statistics for 1961 and 1969 for these disease groups.

TABLE III Main cause of disability: percentage in each disease group by degree of disability

Main Disability Group	Degree of Handicap		
	Very Severe	Severe and Appreciable	Minor
	%	%	%
Infective and Parasitic Diseases	—	0.8	1.1
Neoplasms	1.8	0.9	0.8
Allergic, Endoctrine, Metabolic and Nutritional diseases	1.5	1.1	2.0
Diseases of Blood and Blood Forming Organs	—	1.3	0.7
Mental, Psycho-Neurotic and Personality Disorders	3.8	2.5	3.5
Diseases of Central Nervous system	40.1	12.8	8.9
Diseases of Circulatory System	10.2	12.2	18.5
Diseases of Respiratory System	2.7	6.0	11.4
Diseases of Digestive System	1.7	2.4	2.9
Diseases of Genito-Urinary System	2.0	1.4	0.9
Diseases of Sense Organs (excluding blindness)	1.2	5.1	7.9
Diseases of Skin and Cellular Tissue	—	—	0.8
Diseases of Bones and Organs of Movement	28.9	50.0	33.8
Congenital Malformations	—	0.4	0.6
Injuries	—	3.1	4.3
Senility and Ill-Defined Conditions	10.8	3.0	3.9
Amputees	1.5	2.9	5.0
Blind	2.5	1.5	2.7
All Conditions	100	100	100

Source: Table AIII of published report

3.15 In a study of the prevalence of chronic disease and disability in North Lambeth (Bennett *et al*) 1970[10] it was estimated that the central estimates of prevalence of disability, within fairly wide confidence limits, in those aged 35-74 are 7.2 per cent for men and 9.7 per cent for women. In this study disability is defined as the inability to perform unaided, certain activities essential to daily life. Bennett suggests that these data are in close agreement with the findings of a Danish study (Bonnevie 1966) which identified 6.5 per cent of persons aged 15 to 61 as physically handicapped.

3.16 In a pilot survey by Rankine & Weir[11] intended to ascertain the number of chronically ill and disabled persons, above school age and below age 60 in a known population in Fife, and to assess their needs in terms of hospital care and other facilities, the extent of chronic illness and disability disclosed within the age limits and the definition adopted, was 2.63 per thousand population. Allowing for the possibilities of error, it is suggested that the extent is probably of the order of 3 per thousand poulation. From

[10]*Chronic Disease and Disability in the Community: A Prevalence Study* A. E. Bennett *et al*, BMJ 1970 3. 762-764

[11]*An enquiry into the Incidence of Chronic Illness and Disability in the Young and Middle-aged.* (R. Rankine & R. M. L. Weir 1967).

the authors' assessment of each patient, almost one-third of the survey population of 33,000 would have benefited from comprehensive assessment.

3.17 These figures by themselves are not conclusive, but taken together as indicators they suggest that there is a large number of people in the community who derive little long-term benefit from hospital care, or who must place substantial and continuing demands on health and social services.

4 Recent Legislation and Development

4.1 In the past few years, there has been enacted important legislation affecting rehabilitation services in Scotland. There have also been put forward proposals for changes in the medical services of the Department of Employment. The Government Social Survey on the Handicapped and Impaired in Great Britain has recently been completed. Other proposals, of a more general nature, affecting the organisation of health services have also been put forward. All of these are of relevance, directly or indirectly, to rehabilitation services, and it would seem to be of value to describe, in general terms, what appear to us to be the important issues arising from these developments.

4.2 The Social Work (Scotland) Act 1968

We have already commented in Chapter 1 on the general provisions of this Act, and there is no need for further development of these comments. There are, however, several features of the new arrangements which have important repercussions for rehabilitation services, and it would be improper not to expand on these.

4.3 The pattern of social work services provided varies from area to area. Needs are different, and the demands made on the new departments by other services are not always similar. There are many conflicting pressures on Directors of Social Work, and shortage of staff in the short term may make it difficult to maintain an adequate service over the whole spectrum of demand. Assessment of priorities can only be achieved by continuing discussion at all levels with hospital and other services. There is a need to strengthen relationships between health and social work services, so that each professional group may be kept informed of the needs, problems and future plans of the other. Communication is, however, a two-way process, and medical staff have an equal responsibility to initiate such discussion. The impending reorganisation of health services will demand new lines of communication. Administration of the health services will be more flexible, and the social work arrangements will offer new opportunities for closer collaboration.

4.4 Most hospital social workers enjoyed good liaison with local authority services prior to the Act, and this has not changed with the establishment of new Departments of Social Work. It is probable that some social workers may always wish to work in a multi-professional milieu like a hospital or health centre. There are, however, increasing attractions in local authority

ervice, in that it may offer improved career prospects, better salaries and professional satisfaction. If this continues, there is a danger that social work services provided by the health service may become seriously attenuated. The current disparities of salary and conditions of service between the social workers employed by hospital and local authorities should be resolved.

4.5 The health services' system whether it be through the hospital or the community, will reveal many social work problems. The social worker is an essential part of the rehabilitation team. Although the availability of supporting staff may be improved through the improved staffing structure in local authority departments, we consider that there is a need to maintain the existence of a hospital based social worker, skilled in medical aspects of social work.

The pattern of social work training to date has been along specialist lines and many social workers who did not train particularly for work in the health services therefore had little opportunity to study the social aspects of illness. The teaching on this subject has, however, been steadily improving and the changing patterns of training in relation to the different methods of functioning in the local authority departments will require to take this into account. The medical profession can be criticised for lack of awareness of the value of social work staff, but if full time medical social workers disappear, it will be more difficult to remedy this situation.

4.6 While it would be of benefit to expand social work provision in health centres, it is unlikely that there will be sufficient staff to achieve this quickly. Nonetheless every effort should be made to extend the service in this way so that the important needs of the primary care system can be progressively met. At present, general practitioners use health visitors to give medico-social advice. These arrangements should be developed, and if social workers can also be provided in future, this will greatly strengthen the service which the general practitioner can provide.

4.7 The Chronically Sick and Disabled Persons Act 1970

The underlying purpose of the Act is to draw attention to many of the problems of people who are handicapped by chronic sickness and disablement, and to provide measures whereby these problems can be made known, studied and action taken to find solutions. It provides, inter alia, for provision to be made for means of access and other facilities for disabled persons in buildings to which the public have access, for special housing for the disabled, for the use of invalid carriages on footpaths, and for greater representation of the disabled on various advisory committees. In addition, it requires the submission of an annual report on research and development work in relation to equipment to increase the range of activities and independence of disabled persons. In some respects, it only brings provision in this country into line with that provided abroad, but it is to be heralded as representing a considerable advance in public concern and awareness.

4.8 Sections 1 and 2 of the Act do not apply to Scotland, since it was accepted that the general duty laid on local authorities by the earlier Social

Work (Scotland) Act 1968 to promote social welfare already covered the specific duties laid on local authorities in England and Wales by the 1970 Act. Section 1 of the 1970 Act lays a duty upon local authorities in England and Wales to find out the numbers of handicapped and disabled persons requiring welfare services in their area of responsibility. The Department of Health and Social Security have suggested to local authorities that they may find it desirable to begin this task by carrying out sample surveys in order to build up an assessment of total demands; to develop the services shown to be required; and only when this has been begun to start to identify all the disabled in their areas who need and want services. It is intended to invite Scottish local authorities to make similar arrangements. We understand also that local authorities on both sides of the border will be asked to prepare plans for the development of all their social work services over the next few years. While these matters are being approached in a broadly similar manner, we consider that the differences in the legislation should be recognised and we would stress that it is necessary to ensure by continuing and careful study that Scottish local authority services for the disabled are no less effective than those in England and Wales.

4.9 The Employment Medical Advisory Service

During 1969, a Bill was introduced before Parliament under which there was to have been created an Employment Medical Advisory Service. This service was intended to embrace the work of the medical inspectorate of factories, the appointed factory doctors, and the medical officers attached to Government Training Centres and Industrial Rehabilitation Units, and to provide advice to industry and the Youth Employment Service, under a unified service, staffed by full-time doctors, although with part-time appointments continuing in the more isolated areas. This proposed legislation was not implemented because of the dissolution of Parliament and the last general election.

More recently certain changes have been made in the establishment of a new Medical Services Division of the Department of Employment. This is intended to incoporate all the Medical Inspectors of Factories, the appointed factory doctors and the part-time medical officers to Government Training Centres and Industrial Rehabilitation Units. The future role of this Medical Services Division in industrial rehabilitation is not yet clear.

4.10 While it is recognised that these proposals were intended to make good certain deficiencies in the present arrangements, we consider that it would be preferable if these medical officers could be more closely associated with medical rehabilitation services. At a time when doctors of all types are in short supply, it is important that the best possible use is made of medical manpower in rehabilitation.

4.11 The Government Social Survey on the Handicapped and Impaired in Great Britain

During the latter part of our discussions, there was published the report of the Government Social Survey on the Handicapped and Impaired in Great

Britain to which reference was made in Chapter 3. With the time and resources at our disposal, we have not been able to study the results of this survey in detail. We are encouraged, however, by the fact that at last an attempt has been made to measure the prevalence of disability in the community, the use made of supporting services and the gaps in provision. With the availability of this data, many valuable developments should take place.

4.12 Re-organisation of the Scottish Health Services

Towards the end of our discussions there was published the Government's White Paper (Cmnd 4734) on *Reorganisation of the Scottish Health Services,* setting out the Government's proposals for reform of the administrative structure of the National Health Service in Scotland. The administrative changes it proposes are designed 'to enable doctors, nurses and other health care professions to work together with greater ease and effect for the benefit of their patients and the whole community'. The proposed unification of the organisation and management of hospital, family practitioner and local authority health services under 14 Health Boards will promote an integrated health care system.

4.13 Doctors in an Integrated Health Service

At the same time, there was published the report of a Joint Working Party on *Doctors in an Integrated Health Service,* which suggests the way in which different branches of medical practice might work together in an administratively integrated service. The provision of a comprehensive rehabilitation service should be facilitated by the proposed changes, which seem to be wholly compatible with our recommendations. Elsewhere in this report, we suggest that there will be a need to review the progress made in developing rehabilitation services. Any such review should take account of any features of the changes in structure and organisation brought about as a result of these reports.

5 Medical Rehabilitation Services—Content, Functions and Structure

5.1 One of our early conclusions about the means by which rehabilitation services might be improved was to ensure positive co-ordination of those involved. The process of rehabilitation is complex, and has a variety of aspects—physical, social, psychological, educational and industrial. The priorities for action in one or other of those spheres varies from time to time.

5.2 Because of this, we considered whether the social worker or some other non-medical member of the treatment team might provide the necessary co-ordination and direction, but we came to the conclusion that none had the necessary depth or breadth of knowledge or training about the multiple factors involved in medical rehabilitation.

5.3 We then sought to define the role of hospital medical personnel in rehabilitation. Traditionally, each hospital consultant with clinical commitments retains responsibility for his own patients at all stages of their treatment in hospital. Nonetheless, the demands made upon him in diagnosis and in treatment of the disease entity largely absorb his time and professional capacity. The involvement of many consultants in rehabilitation is confined to making use of the services of the physiotherapist or the occupational therapist or the social worker. For a large proportion of patients, routine clinical management, in association with the assistance of physiotherapy and occupational therapy, is sufficient to ensure restoration of function. For some patients, the social and vocational aspects of therapy can be dealt with adequately by the social worker. Often, however, there is an uneasy and at best tenuous relationship between the hospital clinician and other departments within the hospital which participate in the process of rehabilitation, and between the clinician and the rehabilitation agencies working outwith the hospital.

5.4 In certain specialties, however, such as geriatrics or psychiatry, rehabilitation is seen as more than the introduction of particular techniques. The psychiatrist and the geriatrician adopt an approach which is holistic. That is to say, in their techniques, they are obliged to take into account the whole man in a psycho-socio-somatic way. It cannot be argued that in these specialties, the number of patients is small, and that is only this which permits involvement beyond the perimeter of the hospital. What is possible in these specialties should in theory be possible in other specialties.

5.5 We spent some time, therefore, considering whether it was practicable to seek to extend the function of the clinical specialists. There is a clear need

to develop an awareness of the breadth of the rehabilitation process amongst the medical profession in general, and this, once achieved, would do much to ameliorate the present inadequacies in co-ordination and communication.

5.6 We concluded, however, that the restoration of patients requiring special or prolonged rehabilitation to full working capacity, to enable them to adjust to the demands of modern society or to live with residual handicap, is, in many cases, outwith the training and experience of the average consultant. Rehabilitation and resettlement of this nature is a daunting prospect. It can be long drawn out, and may involve an immense amount of time and effort which, by the daily burden of other clinical duties, can be ill-afforded. This is particularly so in the later stages of treatment, when the patient's problems as a social being are becoming more demanding and require a different expertise. While some consultants can obtain the maximum benefit from supporting facilities, many do not. Nonetheless, it is an ideal towards which all should strive. Even if this should at some date be realised, however, there will always remain a number of patients presenting complex problems whose solution will require special skills.

5.7 For the same reason, while the general practitioner has a vital role in rehabilitation services, which is described in paragraph 5.16, we did not consider that he was the person to lead the hospital rehabilitation team, even if general practitioners have in future a closer involvement in the hospital. This view was supported by the evidence of the Royal College of General Practitioners which suggested that the general practitioner should have access to a 'rehabilitation expert'.

5.8 There are three main aspects of medical rehabilitation—the identification of those who require it; the application of techniques of rehabilitation; and the functional assessment of the capacity of the individual to participate in the life and work of the community. Each of these is an exercise in co-ordination, since each requires the participation of others with different professional skills. Medical rehabilitation must therefore embrace all these skills, and yet at the same time it must not supplant them.

5.9 In England and Wales, there has evolved over the years, a close association between Physical Medicine and Rheumatology as a 'dual' specialty. Such a development has not taken place to the same extent in Scotland. It has been argued that it is essential that a consultant responsible for rehabilitation services should combine this with a separate clinical responsibility, since without this the specialty might lack clinical appeal and would fail to attract recruits. The whole future of rehabilitation would suffer in consequence.

The opposite view is that rehabilitation is a separate and important discipline in its own right. Moreover, proponents of separation of the specialty argue that consultants in physical medicine have failed to exploit the opportunities which exist in regard to ergonomics, applied physiology, electromyography and broad problems of social and psychological adaptation.

While minority opinions were expressed on both extremes of this spectrum of opinion, the majority view was definitely in favour of the separate development of Medical Rehabilitation.

In examining this matter, we had regard to the evidence submitted by the Royal Colleges of Edinburgh and Glasgow, from which we noted considerable support for the appointment of such a specialist.

5.10 The Creation of a New Specialty

Having sought to assess fully the many difficult problems associated with the creation of a new specialty of 'Medical Rehabilitation', we became convinced that the identification of a new specialty of medical rehabilitation is the principal requirement, if leadership and direction is to be given to rehabilitation services. **We recommend,** therefore, that Medical Rehabilitation should be recognised as a specialty in its own right.

5.11 The Functions of a Consultant in Medical Rehabilitation

The duties of the consultant in medical rehabilitation should be as follows:

(a) To assist with the identification and evaluation of disability in patients requiring specialist rehabilitation.

(b) To have administrative responsibility for the remedial departments within a hospital.

(c) To have clinical responsibility for patients referred directly to him.

(d) To offer guidance on the preparation of a planned programme of rehabilitation for individual patients following multi-discipline assessment, in association with the clinician responsible for the patient, by the employment of modern methods of assessment.

(e) To ensure continuity of care of patients, by supervision of the scheme of rehabilitation, and by co-ordination of the work of the agencies involved.

(f) When appropriate, to prescribe a definitive programme of rehabilitation.

(g) To provide a consultant service in rehabilitation to the general practitioner, whether in hospital, in the health centre, or in the home.

(h) To undertake research into the mode of action and value of a wide variety of methods of treatment, and into the effects of environmental factors on disease at work and at home.

(i) To encourage in his clinical colleagues a positive attitude towards rehabilitation.

(j) To teach undergraduates, hospital staff and general practitioners in the practical aspects of rehabilitation, and thus help to ensure that there is created a wider and deeper understanding of the contribution of planned rehabilitation.

5.12 The Structure of Medical Rehabilitation Services

In the establishment of any new discipline such as is described in this report there is always a problem of recruitment because of the scarcity of people with the requisite qualifications. Our immediate recommendations relating to structure take this into account. Much will depend on the initial impetus which can be given in establishing the specialty which, in turn will depend on the quality of candidates appointed. The development of medical rehabilitation services will present considerable problems and for this reason **We recommend** that its progress should be subject to continuous appraisal and formal review.

5.13 We recommend that, intitially, consultant appointments in Medical Rehabilitation should be made only in teaching hospitals. This is suggested for two reasons. First, the number of candidates with suitable qualifications for consultant posts is likely to be limited, and appointments on a wide scale would not be practicable or desirable. Secondly, the Consultant in Medical Rehabilitation will have important teaching responsibilities. Only in this way can a cadre of suitably trained doctors emerge for expansion of the service. While we make recommendations in Chapter 8 for supporting University appointments in Medical Rehabilitation, and describe what we consider should be the range of teaching in rehabilitation, the Consultant in Medical Rehabilitation will also have an important role in systematic teaching. The more widely known rehabilitation can be made, the earlier should occur that improvement in knowledge and attitude which is so urgently required.

5.14 The appointment of single-handed consultants in any specialty is not favoured and rehabilitation is no different in that sense from other specialties. Nonetheless, it is unlikely that more than one or two appointments could be made, even in teaching centres. It may be necessary therefore for single-handed consultants to be appointed and for them to rely initially on cover from colleagues in University Departments. This will be by no means an ideal arrangement, but we are unable to suggest any other. The provision of a training programme, which is described in the ensuing chapter, and ultimate growth of the specialty, should in time permit the establishment of proper arrangements.

5.15 Supporting Staff

An essential concomitant to the appointment of consultant staff will be the appointment of adequate numbers of medical staff in the training grades, having regard to the opportunities presented by an expanding service. **We recommend** that, after consultant staff have been appointed, Regional Boards should take steps to ensure that appropriate supporting staff are appointed.

5.16 General Practitioners

Although the responsibility for carrying out a rehabilitation programme should generally rest with specialists in medical rehabilitation, the majority

of disabled persons are in the community, and therefore under the care of general practitioners. This is an area in which there is great potential for development. The provision of health centres offers an opportunity to provide a co-ordinated treatment plan for each such patient. The general practitioner, supported by health visitors and other rehabilitation staff is in a position to identify patients whose illness or injury seems likely to cause difficulty in returning to normal living. As soon as it became apparent that a problem existed which would not respond to routine measures, comprehensive assessment of health, family circumstances, occupational history, intelligence, aptitudes, interests and disposition could be carried out.

5.17 General Practitioners will be able to differentiate between those who can be effectively handled at primary care level and those patients who present complex problems of treatment and after care. The latter will almost certainly require the involvement of the specialist in rehabilitation; the former present the general practitioner with an opportunity for playing a vital role in the provision of a comprehensive rehabilitation service.

5.18 There are at present changes taking place in the organisation of the work of the general practitioner, and many are developing a special interest in certain areas of medical care. If rehabilitation services are to develop in a community setting, all general practitioners should be imbued with 'the rehabilitation approach'. Individual general practitioners should be encouraged to develop a particular interest in rehabilitation. The work of a hospital department of rehabilitation is eminently suitable for participation by suitably trained general practitioners, particularly as this complements his work in the community.

5.19 Future Staffing Structure

The future development of medical rehabilitation services must await clearer definition of the workload. This will be one of the tasks undertaken by the initial appointees to consultant posts. We anticipate, however, that ultimately there will be established Chairs in Rehabilitation (see Chapter 8); and that each district general hospital may have two consultants in Medical Rehabilitation, with necessary supporting staff, and will have commitments not only in hospitals, but in health centres, Industrial Rehabilitation Units, and in industry. It is our view that the staffing of medical rehabilitation services must be examined not only in relation to the needs of the health service, but also in relation to the needs of the other organisations involved in the provision of rehabilitation services.

5.20 Summary of Conclusions and Recommendations

1 The restoration of patients requiring special or prolonged rehabilitation requires special skills. Medical Rehabilitation should be recognised as a specialty in its own right (*Para. 5.6 and Para. 5.10*).

2 Because of the particular problems associated with the development of a new specialty of medical rehabilitation, its progress should be subject to continuous appraisal and formal review (*Para. 5.12*).

3 Consultant appointments in medical rehabilitation should be made initially only in teaching hospitals (*Para. 5.13*).

4 Regional Boards should take steps to ensure that appropriate supporting staff are appointed, having regard to the opportunities presented by an expanding service (*Para. 5.15*).

5 The general practitioner has a vital role in the provision of a comprehensive rehabilitation service, and individual general practitioners should be encouraged to develop a particular interest in rehabilitation (*Para. 5.18*).

6 Relationship with other Specialties and Services

6.1 The establishment of a new specialty will clearly create problems of adjustment and assimilation with other specialties. In the preceding chapters, the functions of the consultant in medical rehabilitation have been described, and the organisational pattern of rehabilitation services outlined. It would be of benefit, and it might facilitate the process of assimilation, to describe the way in which the relationship between medical rehabilitation and certain other specialties might develop. Obviously, it is not possible to describe a relationship which is appropriate for all circumstances, or for all time. Much will depend on the personalities and abilities of those concerned.

6.2 Medical Rehabilitation and Physical Medicine

In Norway, there exist, as separate specialties, rehabilitation and physical medicine, and it was suggested that this merely exemplified the breadth of rehabilitation services. While we are unable to put forward recommendations for the further development of physical medicine in Scotland at the present time, it is clear that there should be close co-operation between specialists in medical rehabilitation and physical medicine.

6.3 Medical Rehabilitation and Geriatrics

Prominent in the development of comprehensive rehabilitation services in Scotland have been consultants in geriatric medicine, and the care of the geriatric patient has always been seen to extend beyond physical rehabilitation. In essence, rehabilitation starts when the elderly person calls upon his doctor. It continues in hospital, whether by day hospital treatment or in patient care, and extends into the community, by continuous after-care and follow up. Nevertheless, although the greater part of rehabilitation will continue to be undertaken by individual clinicians, the consultant in medical rehabilitation would have a useful role in a geriatric department, as a source of expert help for patients with complex problems.

6.4 Medical Rehabilitation and Psychiatry

As in geriatrics, the psychiatrist is interested in a total theory of rehabilitation, which embraces employment, re-integration with society, and the ability to live outside the hospital, as well as medical aspects of recovery. The devlopment of rehabilitation services in psychiatric and subnormality hospitals will be enhanced by the availability both of social work services and medical rehabilitation services, with which close liaison can be main-

tained. In this field, fusion of hospital and community resources and responsibilities is required. There is a need for continuous association with psychiatric practice during the training of the consultant in medical rehabilitation, and this will be of considerable assistance in fostering a close association in the provision of services.

6.5 Medical Rehabilitation and Paediatrics

We have briefly described the organisation of paediatric assessment clinics, and we need only re-affirm the view that the consultant in medical rehabilitation would have an important function in supervising the processes of transition of care throughout childhood to adolescence and beyond.

6.6 Medical Rehabilitation and the Regional Medical Service

Repeated emphasis has been given to medical and work assessment and the important place they should have, both in hospitals and in industrial rehabilitation units. Both the Department of Employment and the Department of Health and Social Security refer patients to the Regional Medical Service. Some of these referrals may be of persons with varying degrees of physical and social disability who have, so to speak, fallen through the net of other parts of the system. In some instances, the medical disability of such individuals may arise and be treated outside the hospital. In others, when incapacity may be of a long-term nature, residual function can only be assessed long after discharge from hospital. Despite the improvements which should follow the acceptance and implementation of the recommendations in this report, it seems probable that there will continue to be a considerable number of such referrals.

6.7 In this part of their duties, Regional Medical Officers have long performed a very important and essential function in the assessment of such persons referred to them. In the more complex cases, however, where social, psychological and domestic problems obtrude, the time available for comprehensive examination may be inadequate. There will clearly be a place for collaboration between the Regional Medical Service and the specialist in medical rehabilitation in assessment of these difficult cases.

6.8 Studies in both Stockholm and Malmo in Sweden have shown that this is a field which, when intensively cultivated, can yield very worth-while returns in terms of restoration of individuals to the normal stream of productive work and self-sufficiency in society. Indispensable to these successful efforts in Sweden, however, is the assistance of social workers, in the ratio of two social workers to one doctor.

6.9 This is an area, as ill-defined as it is likely to be productive, of unmet needs both in rehabilitation and resettlement, and in medical and social assessment which seems to be the necessary prerequisite. **We recommend** that a study should be undertaken to review and assess the size and extent of the problem of rehabilitation in this field.

6.10 Medical Rehabilitation and the Department of Employment and Social Work Services

This report embraces the development of medical rehabilitation services within the health service, although it has been necessary to refer to the fact that rehabilitation extends beyond the health care system, and beyond the skills of any one individual. We have tried to suggest that the rather rigid line of demarcation which now exists between hospital and community services should become rather less finite, and rather more blurred. In suggesting this, it is appreciated that there is thereby created a 'grey area' between the medical, industrial and social elements of rehabilitation.

6.11 This is an important area of concern, and we are conscious of this. We do not seek to specify how services should operate within this 'grey area', nor indeed do we consider it desirable to do so. There are no 'end-points' in care, and services of different agencies must operate within the areas of responsibility of the others. As the doctor requires the support of the Disablement Resettlement Officer and the social worker, so too the social worker and the Disablement Resettlement Officer require the support and advice of the consultant in medical rehabilitation. The development of a Medical Rehabilitation service offers the opportunity to build bridges between various areas of development in health and community services, and all concerned must ensure that these bridges are seen not as outer defences, to be guarded against all intruders, but as pathways to common understanding and service.

6.12 Summary of Conclusions and Recommendations

1 Although further development of physical medicine in Scotland is not recommended at the present time, there should be close co-operation between specialists in physical medicine and medical rehabilitation (*Para. 6.2*).

2 The consultant in medical rehabilitation has a role in geriatric departments, as a source of expert help for patients with complex problems (*Para. 6.3*).

3 The supervision of the processes of transition of care throughout childhood to adolescence and beyond would be an important function of the consultant in medical rehabilitation (*Para. 6.5*).

4 Continuous association with psychiatric practice is required during the training of the consultant in medical rehabilitation, and this will foster further association in the provision of services (*Para. 6.4*).

5 A study should be undertaken to review and assess the scale of the rehabilitation problems of persons referred to the Regional Medical Service (*Para. 6.9*).

6 The development of medical rehabilitation services offers an opportunity of closer involvement between health and other community services (*Para. 6.11*).

7 The Provision of a Medical Rehabilitation Service—Staffing, Training and Organisation

7.1 Staffing

Having recommended the introduction of a new specialty of medical rehabilitation, it is necessary to consider how, in the absence of personnel with knowledge of such a specialty, the first appointments can be made. It has already been suggested that, initially, there may be a few candidates with satisfactory qualifications for such posts, and that it would accordingly be necessary to limit the number of appointments made. It is important that only suitable people are appointed to these initial posts because of the need to provide the initial impetus which the service urgently requires. The requirements for a specialist post in medical rehabilitation must be as stringent and exacting as in any other specialty.

7.2 In Appendix VI there is described a broad training programme for consultants of the future and this will also provide general guidance for assessing the qualifications of candidates for these initial appointments. Ideally, during training, candidates should have filled a variety of hospital posts, and should possess a broad background of knowledge and experience. It would be wrong to be too specific about the content of that knowledge and experience, since, probably without exception, those appointed would be in need of further training and experience. There is much to be said for the proleptic appointment of men with the necessary professional and personal qualities, and above all, enthusiasm for this type of work. A large part of the first year of the appointments would have to be spent in travel, to afford the opportunity to study in depth the techniques of established rehabilitation centres both in this country and abroad. Appointing authorities should accept the need for such a period of further training, and should provide opportunities and financial assistance for it. In planning programmes of further training particular consideration should be given to including attachments to rehabilitation departments abroad.

7.3 Vocational Training in Medical Rehabilitation

In an earlier chapter, it was recommended that suporting posts in medical rehabilitation should be established. Some of these will be training posts. whose occupants will aspire to fill consultant posts at some future date, and their vocational and academic training is of considerable importance. Since training arrangements must provide for a variety of background experience, and the needs of the individuals concerned, there is outlined, in very general terms, in Appendix VI, the broad requirements of a training programme in medical rehabilitation. It may be that some of the formal

elements in such a programme, which should include systematic and clinical training, as recommended in the Report of the Royal Commission on Medical Education[12], will have to be undertaken by a particular University Medical School. With the recognition of medical rehabilitation as a specialty it would be appropriate to recognise the special medical training which will be required of prospective consultants. **We recommend** that the Scottish Royal Colleges, the Scottish Universities with Medical Schools and other appropriate bodies be invited to consider the formulation of appropriate training arrangements in medical rehabilitation for this purpose.
We further **recommend** that the attention of the Scottish Council for Postgraduate Medical Education be drawn to our proposals, so that in due course its Regional Committees can consider the provision of local arrangements for postgraduate training in accordance with any recommendations made by the Standing Joint Committee.

7.4 The Organisation of Rehabilitation Services

It is particularly difficult to suggest a plan for the organisation of rehabilitation services when for some years the resources available, both in terms of manpower and accommodation, will be far from adequate. Much will depend on the qualities and interests of the successful candidates, some of whom, for example, may be drawn from General Medicine, Orthopaedics, Physical Medicine, or Geriatrics. In hospitals with established divisional systems, the consultant in medical rehabilitation might be a member of both medical and surgical divisions. As a member of these divisions, he could make known to his colleagues the scope of his work and seek their co-operation in identifying patients requiring rehabilitation. It will undoubtedly take time for hospital staff to learn how to use the Consultant in Medical Rehabilitation. Essentially the Consultant in Medical Rehabilitation would provide a specialist service in rehabilitation for all the clinicians in a hospital. In the same way as laboratory medicine provides positive support for the clinician, without in any way impeding the clinician's individual responsibility for his patient, the consultant in medical rehabilitation would be available to discuss and assist with the management of patients presenting complex problems of rehabilitation and resettlement. For some patients, the consultant in a specialty will initiate rehabilitation measures on his own, for others, he will at an early stage seek guidance from the consultant in medical rehabilitation on the preparation of a programme of rehabilitation. Some doctors may pass responsibility for the supervision of that programme to the consultant in medical rehabilitation.

7.5 The organisation developed in paediatric assessment clinics is equally relevant to the organisation for rehabilitation clinics. Initially the chairman of the assessment team might be the consultant in clinical charge, particularly in the early stages of treatment when the principal objective is assessment for therapy. The consultant in medical rehabilitation would participate in this assessment, with the other members of the rehabilitation team. Latterly however, when the objective is assessment for discharge or employment, the consultant in medical rehabilitation would co-ordinate all the activities

[12] *Royal Commission on Medical Education,* 1968 HMSO Cmnd 3569

of the team, and act as the bridge between the hospital and the external agencies which would help to support the patient. Prior to the discharge of each patient, a full assessment of the patient's ability to return to work should be made and appropriate arrangements made for follow-up and after care.

7.6 For the general practitioner, medical assessment clinics in the hospital under the charge of the consultant in medical rehabilitation would be open access clinics, to which he could refer patients posing complex problems. The consultant in medical rehabilitation would also hold assessment clinics in the health centre. It is essential that there should be regular communication between the consultant in medical rehabilitation and the general practitioner.

7.7 Area Co-ordination

The preceding paragraphs have sought to describe the organisation of rehabilitation services within the health service, but of course rehabilitation extends beyond that limited field. It would be of great benefit if in each health board there were established some mechanism whereby the various agencies involved in rehabilitation services could meet to discuss common problems. Although the consultants in medical rehabilitation would be in regular communication with officers of the Department of Employment and the Directors of Social Work in each area, there would be merit in constituting a committee or working party to co-ordinate and plan the development of rehabilitation services. We have been concerned to note how little is known on all sides about the work and difficulties of other agencies in rehabilitation services, and the constitution of some co-ordinating mechanism would help to overcome this problem. We therefore **recommend** that each Regional Board, (and ultimately each health board) should seek to establish some mechanism which is representative of all the interests concerned in rehabilitation, both in the hospital and in the community, to review and advise on arrangements for their co-ordination.

In addition, it is essential to ensure some means whereby the concept of rehabilitation will permeate all clinical disciplines within the hospital. How this can best be achieved within the divisional system is a matter fordiscussion.

7.8 National Co-ordination

Throughout our review of rehabilitation services, we have been continually made aware of the interdependence of the various rehabilitation services provided by different official and voluntary bodies. Our terms of reference precluded our making any detailed reference to the services provided by other agencies, but it would be desirable to ensure that the development of rehabilitation services in the health service is related to developments in other fields. It has already been recommended that our proposals should be subject to continuous appraisal and review. Because of the multiplicity of Government Departments and voluntary bodies involved in rehabilitation, we see a need for some inter-Departmental Committee whose continuing concern should be the review and co-ordination of all rehabilitation and resettlement services. **We recommend** that consideration should be given to the establishment of such a committee.

7.9 Summary of Conclusions and Recommendations

1 Appointing authorities should accept the need for further training of doctors appointed to new post in Medical Rehabilitation, and should provide opportunities and financial assistance for it (*Para. 7.2*).

2 The formal elements in the training programme in medical rehabilitation may have to be undertaken by a particular University medical school (*Para. 7.3*).

3 The Scottish Royal Colleges, the Scottish Universities with medical schools and other appropriate bodies should be invited to consider the formulation of training arrangements in medical rehabilitation (*Para. 7.3*).

4 The attention of the Scottish Council for Postgraduate Medical Education should be drawn to the proposed training arrangements in Medical Rehabilitation (*Para. 7.3*).

5 The Consultant in Medical Rehabilitation would provide a specialist service in rehabilitation for all the clinicians in a hospital (*Para. 7.4*).

6 The general practitioner would refer patients direct to medical assessment clinics under the charge of the consultant in medical rehabilitation (*Para. 7.6*).

7 Each Regional Board should seek to establish some mechanism, representative of the various interests concerned, to review and advise on arrangements for the co-ordination of all rehabilitation services (*Para. 7.7*).

8 Consideration should be given to the establishment of an inter-Departmental Committee to review and co-ordinate all rehabilitation services (*Para. 7.8*).

8 Teaching and Research in Rehabilitation

8.1 The general lack of awareness of rehabilitation by the medical profession is illustrated by the dearth of original research into the subject, and the limited importance it is given in the undergraduate curriculum. Elsewhere in this report reference has been made to the need for the appointment of specialists in rehabilitation. Such appointments will do much to improve the quality of the service, but by themselves they are insufficient to guarantee continued growth and development. There is a need to develop the academic aspects of rehabilitation in association with the development of 'service' provision, and to ensure future activity in medical education and research. Unless undergraduates are taught to see rehabilitation as an integral and dynamic part of patient care, and unless its importance is constantly stressed to them during training, there can never develop within the profession the awareness which will ensure that rehabilitation is seen not as an afterthought, or the province of the physiotherapist, or social worker, but as a fundamental responsibility of each member of the treatment team.

8.2 The Need for Academic Departments

Evidence of the lack of awareness of the medical profession of the importance of rehabilitation can be seen in the Todd Report on Medical Education[12], which, although commenting at length on the content of the undergraduate curriculum, devoted only some two sentences to the subject. This was substantiated in the evidence received from the undergraduate deans of the four medical schools, and we have no doubt a similar situation prevails in postgraduate education. Rehabilitation must be given academic recognition on terms equal to those of other disciplines, and we are unconvinced that it will be given sufficient importance or receive adequate attention if it is left to the fortuitous interest of a wide variety of clinical teachers.

8.3 In furtherance of these views, we **recommend** that ultimately there should be established separate Departments of Rehabilitation, with a professorial head, in each of the four medical schools. Such a development may seem to be difficult of fulfilment, and it may not be possible to achieve this goal for some time. Candidates with the requisite skills and achievements are few, but the possibility of recruiting from other disciplines should not be ignored. One or two such Departments might be established by some Trust or Foundation.

[12] *Royal Commission on Medical Education,* 1965-68—HMSO Cmnd 3569 (1968)

8.4 In the intervening period, there is a need to establish a sound base for rehabilitation within the medical schools, and we hope that at an early date, appointments may be made in each of the four medical schools, of a Senior Lecturer in Medical Rehabilitation, who would be responsible for systematic teaching and research in medical rehabilitation. Such appointments would provide academic support and research assistance for the Consultant in Medical Rehabilitation.

8.5 The location of such posts will be a matter for each University, but it would seem to be desirable for the appointment to be in a Department within which rehabilitation is given due prominence. This might be for example in the Department of Social and Preventive Medicine, in the Department of General Practice, or in the Department of Medicine. It might be that a number of Departments could combine to establish such a post. It would be helpful for the post to be in a Department where there was access to sources of advice on statistical method, epidemiology or occupational medicine, but above all, where there was a climate of opinion favourable to the development of the subject.

8.6 If there are doubts about the need for such appointments, the potential range of teaching of this Senior Lecturer should help dispel fears of limited content and restricted application. Apart from the obvious needs of undergraduate and postgraduate teaching, bioengineering, ergonomics and applied physiology are areas within which can be foreseen considerable developments which must be related to medical education. There is a need to give emphasis to social work, and problems of re-employment, the availability and effect of State benefits, the mobilisation of community resources, the use of physiotherapy, occupational therapy, and speech therapy. The teaching of nurses, the remedial professions, social workers, and disablement resettlement officers might all be part of his commitments.

8.7 Having sought to define the range of teaching in rehabilitation, certain questions then arise. First, how much systematic teaching should be given, and secondly, how can the medical schools be induced to play their part in its provision?

8.8 Although we were impressed by the amount of teaching time devoted to rehabilitation in certain countries in Europe which we visited, we accept that it is not possible to extend further the medical curriculum, and that there are many pressures for increased teaching time. Nonetheless we are convinced that much greater emphasis must be given to rehablitation in undergraduate teaching, and we were encouraged to note that this view was generally supported in the evidence we received on this subject. In the teaching of every common disease or injury, undergraduates should be instructed in the likely period of disability under the best circumstances, in the specific measures necessary to achieve this minimum period of disability, and in any special conditions of work advisable when the patient returns to employment.

The development of undergraduate teaching in rehabilitation is a matter of such importance that **we recommend** it be brought to the attention of the appropriate University authorities and the General Medical Council.

8.9 Research

In the course of our discussions, we have become increasingly aware not only of how much is known about rehabilitation, but also of the vast fields which still remain to be cultivated. The following paragraphs outline possible areas of research.

8.10 While diagnosis and medical treatment have reached a high degree of clinical and scientific skill, the same cannot always be said of functional assessment, many elements of which remain uncertain and empirical. This was revealed to those of us who visited European centres, where strenuous efforts are being made, by means of applied physiology, to establish, for example, in cardiology, base-lines of normality against which degrees of abnormality can be measured.

8.11 Both in industry and in work assessment units there are opportunities for assessing the psychological, physical and social demands of the work situation.

8.12 With the enactment of the Social Work (Scotland) Act, 1968, social work services have been provided with a firm base in the community from which to exercise their skills. The operation of the social work services in relation to rehabilitation services requires urgent and continuing study.

8.13 Other areas for research could be in appplied physiology, psychiatric aspects of rehabilitation, ergonomics, prosthetics and orthotics, bio-engineering, assessment of the value of various techniques of physiotherapy and occupational therapy. Suffice it to say that the needs are many, the choice for research is wide, and each university could develop its own particular area of interest.

8.14 Summary of Conclusions and Recommendations

1 Because of the clamant need to develop the academic aspects of rehabilitation, ultimately there should be established separate Departments of Rehabilitation, with a professorial head, in each of the four medical schools (*Para. 8.3*).

2 Prior to the establishment of such Departments, we hope that the medical schools may appoint Senior Lecturers in Rehabilitation (*Para. 8.4*).

3 There is a need to develop undergraduate teaching in Rehabilitation. This is a matter of such importance that it should be brought to the attention of the appropriate University authorities and the General Medical Council (*Para. 8.8*).

4 Medical assessment, work assessment, the inter-relationship of health and social work services and other aspects of rehabilitation services offer opportunities for research (*Para. 8.9-8.13*).

9 The Remedial Professions

9.1 Rehabilitation of the disabled demands a team effort. The number in the team will vary with individual circumstances but in most teams members of one or more of the Remedial Professions will have a major role. Speech therapist, social worker, chiropodist and nurse may all participate but the Remedial Professions which make the most direct contribution are the physiotherapist, occupational therapist and remedial gymnast.

9.2 We have been impressed by the desire of members of these professions to improve their contribution to rehabilitation; by their acceptance of the need to improve their professional image with doctors, medical students, other professions and the lay public; by their claim that the medical profession generally is very ignorant of the techniques and skills which the professions can contribute; by their desire to become actively involved in comprehensive assessment clinics and to concentrate their resources where they can function in collaboration with allied professions; by their apparent willingness to consider any modification of their training, and in particular to explore the possibility of achieving a closer integration between the three professions during education and training.

9.3 We are aware that a number of members of the remedial professions hold part-time appointments. Some are in private practice, others have joint appointments and we have found it impossible to obtain accurate data on the numbers in each profession and of the numbers entering and leaving each year. Some statistics of hospital service personnel are given in Appendix VII. Reasoned forecasts of future requirements are not easy to make but there is a clear need to expand recruitment. At present the great majority of members of these professions are women; there is a high wastage rate through marriage; the turnover rate through posts is high, resulting in a lack of continuity. This could be improved if more men could be recruited, training facilities expanded and a more attractive career structure devised.

9.4 At the present time almost all Training Schools have to turn down suitably qualified applicants because of lack of accommodation and of suitably qualified teachers. The existence of a Training School undoubtedly enhances recruitment and engenders local loyalties, but it would not be desirable or possible to attempt to multiply schools too quickly because of the dearth of adequately trained teachers. Until this is remedied we believe that it would be better to expand existing Training Schools wherever possible, although there might well be need to establish a new training school in a region where none exists at present.

9.5 For the future larger 'combined training schools' should be established. Such schools could be allied to existing technical colleges or universities and make use of their facilities, techniques and teaching skills particularly in the provision of common core training in the first year. But in the technical aspects each profession will require its own separate classes while sharing facilities. Joint initial classes and sharing of training facilities could help to further the team spirit which we believe to be essential in modern rehabilitation.

9.6 Recruitment of teachers, especially for Occupational Therapy, is difficult because there is no recognisable career structure to attract interested individuals. Indeed, in Occupational Therapy, intending teachers can obtain the requisite further training and experience only at considerable personal financial sacrifice. Suitable individuals should be encouraged and assisted to attend appropriate post registration courses of instruction at an appropriate University or College to qualify them as teachers. Diploma or Degree Courses appropriate to the Remedial Professions might also be encouraged for those most able to take advantage of this level of instruction.

9.7 Courses for teachers should include two main elements:

(a) Training in educational and teaching methods and techniques.

(b) Further training in and development of professional skills.

There would seem to be merit in centralising such teacher training courses in one national centre.

9.8 The present career structure in the remedial professions is of limited attraction to married women and does nothing to encourage men to enter it as a career. Incentives offered to senior staff and teachers require to be improved considerably and urgently. Appropriate arrangements require to be made to encourage married members of the professions to return to part-time posts when family commitments permit. Consideration must be given to the provision of day nursery, baby care services and other incentives. Time and facilities for post registration study and study leave must be provided.

9.9 When administrative authorities require expert professional advice, such contributions must be recognised by the provision of adequate time from routine duty to provide this service. When there is an established need for a senior member of a profession to act in an Advisory capacity to a Health Board such posts should have official recognition. In any future advisory committee structure the remedial professions should be adequately represented individually and collectively as seems appropriate.

9.10 Much of the load of routine work of the remedial professions could reasonably be delegated to suitably trained aides. Such aides might require six months instruction and could make a very significant contribution in group therapy in particular releasing fully trained staff for more exacting duties. Aides would be required to work under the direct supervision of professionals and never completely independently.

9.11 Summary of Conclusions and Recommendations

1 Medical Students, Doctors and members of other professions **must** become better informed of the range of skills and techniques which the Remedial Professions now provide so that there can be an improved understanding between all personnel involved in rehabilitation services (*Para. 9.2*).

2 Active measures should be taken to increase recruitment of women **and men** to the Remedial Professions (*Para. 9.3*).

3 Appropriate time and financial assistance should be afforded to encourage further professional training especially for those intending to become teachers (*Para. 9.6*).

4 Adequate recognition should be given to those senior staff who act as advisers and clinical supervisors (*Para. 9.9*).

5 The Remedial Professions should be given adequate representation on Professional Advisory Committees at **all** levels of administration in the Health Service (*Para. 9.9*).

6 Training schemes for 'Aides' should be encouraged (*Para. 9.10*).

10 Accommodation and Facilities for Rehabilitation Services

10.1 The absence of suitable accommodation and facilities for rehabilitation is one of the principal deficiencies in existing rehabilitation services. Although most hospitals have departments of physiotherapy, and occupational therapy, these are often separate and distinct departments, unrelated in any way. Some hospitals, however, do have new Departments of Rehabilitation, and others are likely to be provided. The health centre building programme should provide the general practitioner and the other members of the primary health care team with accommodation suitable for their role in a comprehensive rehabilitation service. The detailed content and function of the various treatment areas required in a department of rehabilitation is well set out in Hospital Building Notes. This chapter attempts to identify certain basic principles affecting accommodation for rehabilitation services.

10.2 Day hospital treatment is a developing field of activity in health care, and rehabilitation facilities should be planned to take particular account of this. Appropriate dining facilities should always be provided for day patients, who will constitute a large proportion of the patients attending the rehabilitation department. It would be appropriate for the consultant in Medical Rehabilitation to have access to beds for specialised examinations and patients requiring more prolonged assessment and treatment. At certain centres, the need for a limited number of hostel beds for patients attending from a distance should be kept in mind. Particular consideration should be given to the special transport facilities which may be required both within and outwith the hospital complex in association with the Department of Rehabilitation.

10.3 The Location of Departments of Rehabilitation

Opinions were divided in all the countries in Europe which we visited on the ideal location for Departments of Rehabilitation. Some authorities maintained that it should be part of a large hospital, so that the necessary clinical contacts can be developed and maintained; that the Department can have full access to all the necessary supporting services, and so that paramedical staff are not dispersed unnecessarily. Many thought that separate distinct Departments were too vulnerable, and that they might too easily tend to become isolated from other elements of medical care, in view of the difficulties frequently experienced in establishing rehabilitation services. Others, however, held that Departments of Rehabilitation should be functionally linked with hospitals, but physically separate, because the tempo of activity and general atmosphere are quite different to that of a hospital.

10.4 The sub-committee concluded that hospital Departments of Rehabilitation should be part of the complex of a district hospital. In this way, it will be possible for consultants in medical rehabilitation to foster and develop contact with their clinical colleagues in other disciplines, and at the same time, patients will be able to benefit from the different milieu of the Department with its emphasis on return to normal living.

10.5 District Department of Rehabilitation

The department in the teaching or district hospital would provide a general rehabilitation service for the hospital, and act as a medical assessment centre for patients prior to discharge. Patients would also be referred to the department by general practitioners, who should be encouraged to participate in its work. There should be facilities for complete physical and psychological assessment.

The accommodation in the Department should include workshops of suitable size, preferably with equipment which is related to that in industry in the locality, gymnasia, individual well equipped exercise areas, occupational therapy rooms, a domestic flat, in which it should be possible to mirror each patient's domestic environment, a hydrotherapy pool, with a safe and efficient hoist mechanism, and an appropriate number of interview rooms. Designated accommodation should be provided for the Disablement Resettlement Officer and the hospital social worker. A small conference room is essential. Unless special alternative accommodation is available, appropriate facilities should be provided for children under the supervision of the paediatrician. In a teaching hospital, special facilities would be required for teaching and research.

10.6 Health Centres and their Rehabilitation Facilities

The Health Centre has important functions in a comprehensive rehabilitation service. We have already referred in paragraph 5.16 to the fact that general practitioners are in a unique position to identify those patients who require positive measures of rehabilitation. Many of these will come from the community rather than from hospitals. The general practitioner will have important functions in assessment, patient guidance and in the initiation and supervision of rehabilitation measures. It is not possible at the present time to provide in all health centres, comprehensive physiotherapy and occupational therapy services. Staff required for such services, already in short supply, could be more fully employed in the Department at a district hospital. In the larger health centres, separate from a district hospital, it is hoped there will be increasing scope for the employment of members of the remedial professions. Otherwise their attendance, possibly on a sessional basis, would meet the requirements of health centres for the present but the need for future expansion of services should be kept in mind.

For these functions, only simple facilities and equipment will be required, by means of which the general practitioner can make an informed assessment of the needs of particular patients.

The assessment of activities of daily living could be carried out in the patient's home, by an occupational therapist. While some aspects of this assessment could be undertaken at the health centre, domiciliary assessment should

include recommendations on the need for aids to mobility, feeding, dressing, etc.

10.7 In the health centre, the general practitioner could enlist the aid of the consultant in rehabilitation for particular patients presenting complex problems; routinely there should be available to him, perhaps on a sessional basis, the complex of skills provided by the social worker, the health visitor, the disablement resettlement officer, the occupational therapist and phsiotherapist, so that a prescription for rehabilitation can be prepared for each patient who requires it and steps taken towards its implementation.

10.8 Special Facilities

Although evidence on the question of the treatment of patients with head injury and paraplegia was received, detailed consideration was not given to these questions, or to the needs of other patients requiring special facilities. Nevertheless, some general comments on these subjects are appropriate. Earlier reports have dealt with the needs of some special groups, and in the main, there is little to add to their recommendations. While certain groups of patients require separate and distinct facilities, it is desirable that there should be no proliferation of special units. Such units require considerable support to provide for the effective care of patients suffering from long-term disabling diseases and they should be located in hospitals, or close to hospitals capable of providing this.

10.9 Geriatrics

The quality and quantity of rehabilitation services for the elderly in Scotland are impressive and while much has yet to be done to improve accommodation, both clinicians and hospital authorities have clearly defined plans to extend and improve these facilities. The present practice is to provide rehabilitation for geriatric patients separate from those for other patients. There is no reason to suggest that this should be changed.

10.10 Psychiatry

As in geriatrics, the physical needs of rehabilitation services in the field of psychiatry appear to have been defined by hospital authorities. Most psychiatric hospitals have occupational therapy departments, with some form of industrial therapy facilities. Most have plans for extension or replacement of those facilities. It is of advantage if industrial work is organised in such a way that it resembles an actual industrial situation. This can be achieved by the establishment of a hospital factory-type unit, with clocking-in systems, varying pressure of work, regulations concerning dress, smoking, tea-breaks, financial incentives, etc. **We recommend** that hospital authorities be asked to review their needs for industrial therapy with a view to the provision of adequate facilities.

10.11 A particular problem which arises in psychiatric hospitals is the organisation of suitable and continuing forms of employment. There is a

need to obtain work which is capable of being broken down into simple operations, and experience and expertise in assessing the potential of particular contracts is required. **We recommend** that consideration should be given to the co-ordination of contracts for such work within each health board. This might avoid unnecessary overlap and competition.

10.12 Greater progress in the establishment of day hospitals has been made in geriatrics than in psychiatry, although it is generally recognised that day care is likely to be an area of considerable development in the future. Psychiatric services should be given the opportunity to develop day care facilities.

The demand for group homes, hospital annexes, day care facilities and hostel type of accommodation for various types of psychiatric patients is considerable. **We recommend** that special steps be taken to review the rehabilitation needs of the mental health services in each area in order that the role of the various authorities involved in the provision of these facilities can be more precisely defined.

10.13 Head Injuries

The combination of disabilities, mental and physical, suffered by patients with head injuries makes it difficult for them to derive the maximum benefit from existing rehabilitation facilities. Because of this many patients fail to realise their full potential for recovery, or their recovery period is unduly prolonged. The increasing number of head injuries, and reduced mortality, is resulting in more and more survivors with brain damage; many of them require a period of rehabilitation whilst some will need long-term or even permanent care of some kind. Special skills in physiotherapy, occupational therapy, speech therapy, psychology and nursing are required for their rehabilitation. It would be better if the few patients presently accommodated in separate hospitals could be brought together in at least two centres, serving the whole of Scotland. It would seem to be preferable to develop special centres of this kind, and thus both deploy limited reserves of skill to best advantage, and provide concentrated opportunities for research into an ever growing problem. There is no doubt that patients and relatives would accept such an arrangement notwithstanding its possible inconvenience, if adequate facilities were provided. In support of such centres, accommodation should be provided in a psychiatric hospital for patients with severe disturbance, who constitute a not insignificant proportion of the workload. Initial rehabilitation would be undertaken in a special unit supported by second line beds, or beds in a psychiatric hospital, and after initial treatment, a large number of patients could then go to a general department of rehabilitation.

10.14 Detailed consideration of how such facilities might best be provided is beyond the scope of this Committee, in that it involves decisions of national policy and requires the participation of others with responsibility for such decisions. The provision of facilities for the rehabilitation of head injury patients is an immediate and pressing problem. **We recommend** that urgent consideration be given to it.

10.15 Paraplegic Units

The aim of rehabilitation of the paraplegic is a simultaneous physical rehabilitation of maximum independence, training in care of skin, bladder and bowel, and psycho-social readjustment and resettlement. Despite many advances in treatment, the development of pressure sores and urological complications present continuing problems, requiring some special medical and nursing skills. Very often physical rehabilitation may be the simplest problem to be solved. Skin and urological difficulties may be recurring problems years after initial discharge, and continued medical supervision from a specialised unit may be required. These patients would not normally attend a general rehabilitation department, although particular patients might well be referred on occasion to the rehabilitation department in a teaching hospital.

There are at present two paraplegic units in Scotland. In a few years time, an increasing number of paraplegic children, presently in the care of paediatric and social services will reach adolescence, and will require continuing care as adults. The need for additional facilities should be kept under review.

10.16 Epilepsy

The report of the Sub-Committee on the Medical Care of Epilepsy in Scotland, published in 1968[13], dealt at some length with the rehabilitation of epileptics, and hospital authorities have recently reported to the Scottish Home and Health Department on its implementation. We have nothing to add to its recommendations.

10.17 Young Chronic Sick

The needs of the Young Chronic Sick were examined in detail in 1964 in the Macdonald Report[14], and in consequence this question has not been re-examined.

10.18 Limb Fitting Services

The needs of the Artificial Limb Service have been fully dealt with in the Denny Working Party Report[15]. The artificial limb service in Scotland is already highly developed, and the steps being taken to implement the recommendations in this report will ensure that it maintains this development. It is important, however, that the artificial limb service should be seen in the context of a comprehensive rehabilitation service. Many of the needs of the amputee and other patients requiring rehabilitation are identical, and could be adequately catered for in one department, with consequent savings in staff and accommodation.

[13] *The Medical Care of Epilepsy in Scotland.* HMSO 1968
[14] *The Young Chronic Sick.* HMSO 1964
[15] *The Future of the Artificial Limb Service in Scotland.* HMSO 1970

10.19 Summary of Conclusions and Recommendations

1 The planning of rehabilitation services should take account of the increasing development of day hospital facilities (*Para. 10.2*).

2 The Consultant in Medical Rehabilitation should have access to beds for specialised examinations and prolonged assessment (*Para. 10.2*).

3 Particular consideration should be given to the transport requirements of the department of rehabilitation (*Para. 10.2*).

4 Hospital departments of rehabilitation should be part of the complex of a district hospital (*Para. 10.3*).

5 The functions and accommodation of a district Department of Rehabilitation and Health Centre Department are described (*Para. 10.5 and 10.6*).

6 Rehabilitation facilities for geriatric patients should be separate from those for other patients (*Para. 10.9*).

7 Hospital authorities should be asked to review their needs for industrial therapy facilities (*Para. 10.10*).

8 Consideration should be given to the co-ordination of contracts for industrial work within each health board (*Para. 10.11*).

9 Special steps should be taken to review the rehabilitation needs of the mental health services in each area so that the role of the various authorities involved can be more precisely defined (*Para. 10.12*).

10 Urgent consideration should be given to the provision of facilities for the rehabilitation of head injury patients (*Para. 10.14*).

11 The artificial limb service should be seen in the context of a comprehensive rehabilitation service (*Para. 10.18*).

11 Aids and Appliances

11.1 Dissatisfaction with the methods of provision of aids and appliances for the disabled was expressed at an early stage in our enquiry. Opinions on this point have been taken from many sources, in addition to making enquiries during the visit to Europe. Concern has been voiced on this matter for some time and while some improvements have been obtained, it appeared to us that there were many aspects of the problem which could be remedied without great expenditure, but with benefit to the patient. In proferring recommendations on this subject, we appreciate that it is a prime objective in medicine to restore function rather than to depend on aids and appliances. Nonetheless, both in the short-term and in longer term situations, much help and relief can be afforded to disabled patients by the careful prescription of well designed and manufactured articles of this type.

11.2 The Piercy Committee examined the question of aids and appliances in some detail in 1957, and many of its recommendations have become statutory since the enactment of the Chronically Sick and Disabled Persons Act, 1970, particularly in relation to suitability of housing, and means of access to public buildings and transport. That Act also requires the submission of an annual report on research and development work undertaken by or on behalf of any Government department in relation to equipment which might increase the range of activities, independence or well-being of the disabled.

11.3 Of particular interest and assistance is the report 'Aids for the Disabled' issued by the British Medical Association Planning Unit in 1968.[16] This comprehensive and useful report deals in considerable detail with most of the points which concerned us, and it is our intention only to emphasise certain general improvements, which, from consideration of the report, and from evidence supplied to us, seem to be urgently required.

11.4 In the course of our review, we noted the recommendations of the Working Party on the Artificial Limb Service in Scotland. We endorse wholeheartedly their recommendations for the supply of artificial limbs, and develop further in paragraph 11.16 their recommendations for the establishment of a unit to undertake prosthetic research and development.

11.5 In reviewing present arrangements for the provision of aids and appliances, it seemed to us that the matters of particular concern were the dissemination of information about the existence, purpose and value of aids

[16] *Aids for the Disabled*—BMA Planning Unit Report No. 2 1968

and appliances to doctors, nurses and patients; the manner of prescription and supply of aids and appliances; and co-ordinated research into their need, efficacy and manufacture.

11.6 Dissemination of Information

At the present time, the majority of medical undergraduates and graduates and nurses remain alarmingly ignorant of the existence, purpose and availability of many aids and appliances. This usually applies to patients also, although occasionally the impetus to make provision comes from patients and their relatives. On such occasions, the doctor may find himself embarrassingly ignorant of how to achieve or obtain what is required. We have noted with interest the steps recently taken by the Disabled Living Foundation to ameliorate this situation. In addition to mounting a permanent exhibition in London, the Foundation provide, on a subscription basis, an information service for the disabled, for hospital and local authorities, voluntary organisations and interested individuals. As part of this service, information leaflets are issued every two months, the subjects including wheelchairs, beds, tables, hoists, etc., and aids to assist function, such as eating and drinking aids, personal toilet, cooking and communication aids; facilities for training, education, employment.

The British Red Cross have also been actively involved in this field for some time, and produce a catalogue of aids which is deceptively simple in presentation, and yet in content is remarkably comprehensive. Other voluntary organisations, such as the National Fund for Research into Crippling Diseases, the Sembal Trust, and, in Scotland, the Simon Square Centre run by the Edinburgh Cripple Aid Society, and many more, have also sought to remedy the situation. The Scottish Hospital Centre has also been active in this field.

11.7 Notwithstanding the valuable work undertaken by these organisations, we consider that statutory authorities should participate more directly in this information service. Information about aids can be made available in different ways, and both the central department and hospital authorities have a part to play. In submitting the following recommendations, we have sought to devise solutions to the problem which are comprehensive, varied in approach, and not wholly dependent on the written word.

11.8 We recommend that items of equipment designed to assist the handicapped, with details of their value and how to order them should be the subject of articles in official publications such as 'Prescribers Journal', just as new drugs are evaluated in this way from time to time.

11.9 We recommend that consideration should be given to the production of a national (UK) illustrated catalogue of aids and appliances, in conjunction with a scheme of evaluation (*see paragraph 11.14*). This will be a difficult task but evidence from abroad suggests the problem is not insurmountable.

11.10 We recommend that the proposed Departments of Rehabilitation should act as 'information centres' on aids and appliances for the surrounding

area. They should mount a permanent exhibition of Aids to Daily Living, and act as a source of information regarding availability and method of prescription. Temporary exhibitions should be held at Health Centres and Limb Fitting Centres. Demonstrations of equipment to medical students, nurses and other staff could also be arranged at these centres.

11.11 Consideration should be given to using press, radio and television media to make more widely known the services which can be provided by health authorities and social work departments.

11.12 Prescription and Supply

As realisation of the value of team assessment of individual patients by doctors, members of the remedial professions and the social worker increases, the choice of the correct forms of artificial assistance, including domestic modifications, should become simpler and more efficient. The allied professions will bring their special skills to assist the doctor who should, nevertheless, remain the one to make the final prescription. We consider that methods of prescription and renewal of aids and appliances should be simplified and their delivery improved. Renewal of simple items should be possible at Health Centres without further referral to hospital, and in this regard **we recommend** that consideration should be given to extending the prescribing function of general practitioners, who can only prescribe a very limited range of appliances at present. Each hospital and health centre should carry a supply of commonly used equipment for loan purposes. In this latter connection, we consider that it would be of mutual benefit if there were moves towards integration of voluntary effort with statutory services. This might be achieved by voluntary organisations making services available at Rehabilitation and Health Centres wherever possible, to avoid duplication of services, and lack of knowledge of what is available from various sources.

11.13 Research and Development

Many of the items most commonly required for aiding the disabled are firmly established by usage and are frequently manufactured by organisations such as Remploy and others. In other cases there is much need of evaluation and critical appraisal of equipment at various levels: patient requirement, suitability for task in hand; efficacy and standards of manufacture and costs. We were much impressed by the work of the Swedish Institute for the Handicapped, an organisation which combined voluntary effort and government finance to provide research and establish standards in the field of aids. It was all the more impressive that it was partly staffed by technicians trained in the United Kingdom and sent much of its assessment work to this country. It produced a catalogue of fully evaluated items which was widely used in Scandinavia. It also initiated research into new areas of need, and involved hospital staff in its evaluation studies.

11.14 We believe that such an organisation is required in this country to co-ordinate, evaluate and publicise all the excellent work already being carried out by Universities, National Health Service Hospitals and Depart-

ments of Physics and Bio-engineering and by private services. An annual report and catalogue would be of immense value if produced and circulated to all centres and individuals concerned in this work.

11.15 In this connection, we noted the recommendation in the Report of the Working Party on the Artificial Limb and Appliance Service for the establishment of an evaluation unit to assess whether prostheses and other devices supplied to amputees meet patients' needs as well as is technically possible, consistent with economy. We consider that such a unit could successfully embrace aids and appliances in its work, and **we recommend** that consideration should be given to the establishment of such a unit. Among the tasks facing such a research and development organisation would be the definition of the precise performance that is required of particular items. This is often far from straightforward and would require close co-operation between technologists and the appropriate medical and other experts. Similarly, care would have to be taken to ensure that equipment requiring clinical evaluation was assessed on a broad basis and at more than one centre, so that a representative user opinion could be obtained. The success of the whole programme would depend on the collaboration of many agencies outside the unit itself. In addition to undertaking research and development, such a unit could co-ordinate all matters relating to aids and appliances, including publicity and information services.

11.16 Summary of Conclusions and Recommendations

1 Notwithstanding the activities of voluntary organisations in providing information about aids and appliances, statutory authorities should participate more directly in providing an information service on aids and appliances (*Para. 11.9*).

2 Items of equipment for the handicapped should be described in official publications such as the 'Prescribers Journal' (*Para. 11.8*).

3 Consideration should be given to the production of a national illustrated catalogue of aids and appliances (*Para. 11.9*).

4 Departments of Rehabilitation should act as information centres for their surrounding areas, and should mount permanent exhibitions of 'Aids to Daily Living' (*Para. 11.10*).

5 Consideration should be given to using press, radio and other media to make known the services which can be provided by various authorities (*Para. 11.11*).

6 There is a case for the simplification of methods of prescription and renewal of certain aids and appliances. The general practitioner might have an extended function in this respect (*Para. 11.12*).

7 There is a need for a central organisation to co-ordinate, evaluate and publicise all the development work undertaken on aids and appliances. Consideration should be given to the establishment of such a unit, in association with an evaluation unit for prostheses and other devices (*Para. 11.15*).

12 Voluntary Organisations

12.1 It is quite impossible in a short report to summarise the many activities of voluntary organisations in rehabilitation services in Scotland. During the course of our review, we were greatly impressed by the extent of their activities, and the enthusiasm with which these activities were prosecuted. 'An active rehabilitation approach' is clearly evident in their work, and it is not our task to offer recommendations on how they might improve the many services they provide. In this chapter, therefore, we wish merely to review recent developments in the work of voluntary bodies, and to highlight certain factors which suggest to us that, far from improved statutory services resulting in the diminution of voluntary effort, there are signs both of increased activity and of the development of a concerted approach to the solution of common problems.

12.2 Recent Developments

While the older, well-established voluntary bodies have continued to play an important part in dealing with problem areas in rehabilitation, the community in Scotland has thrown up its own voluntary organisations concerned with different types of disability. These organisations have been brought into being by the activities of parents, friends, interested people, and also by the disabled people themselves, and, in the main, they have been concerned with congenital abnormalities and with disabilities of a permanent and possibly progressive type. Although active in pressing for improved treatment facilities, their particular concern has been the creation of a fuller life for the disabled, whether in terms of education, employment, recreation or social integration. Many voluntary organisations also have a special interest in the problems of the families of disabled children and adults. In practically all the activities of these voluntary bodies, there has been increasing involvement with statutory bodies, the latter giving services and in some cases, financial support.

12.3 The Growth of Professionalism

In some organisations, there has always been an element of professionalism. In recent years, however, other organisations have recognised the need for the introduction of staff with special skills and training, and in addition to providing such things as social clubs, sporting facilities, outings, and friendly visits, they have entered into other fields of activity requiring expert knowledge and training, such as social work or occupational therapy. In addition, many voluntary workers have recognised the need for and the value of

special training, and there is evidence of greater willingness to attend special courses of instruction, which may be provided by the staff of statutory authorities.

12.4 There are innumerable examples of voluntary organisations embarking on activities requiring a high degree of professionalism, expert knowledge and the employment of trained staff, in association with voluntary workers. There are units for training the severely handicapped over school age, and for training severely disabled school leavers. Voluntary organisations run sheltered workshops, residential schools, and many other specialised facilities. Others are concerned almost wholly with fund raising activities for research projects. In all cases, they work in close co-operation with statutory bodies. We do not see the growth of these activities as in any way a threat, or a disadvantage, but rather as evidence that voluntary organisations can and will continue to play an essential part in the 'caring' services.

12.5 Improved Liaison and Co-ordination

Although there has been a great increase in the number of voluntary organisations concerned with disability, there has also been a greater appreciation of common aims and needs, and of the benefits of a co-ordinated approach, whether to influence public opinion, to develop special facilities, or to attack a particular problem. As a result, there has gradually developed both central and local co-ordinating organisations for voluntary bodies concerned with disabled people. On a national basis, the Scottish Committee for the Welfare of the Disabled fulfils this function, and, for example, in organising 'Disabled Week' throughout Scotland, it has encouraged the different voluntary organisations to work closely together in a common endeavour. There is a Co-ordinating Committee for the Disabled in Edinburgh and in Glasgow, and also in other areas in the country, and more local committees of this type are being formed. The benefits of such a concerted approach cannot be overstressed, and it is desirable that voluntary organisations should regularly review their arrangements for co-ordination.

12.6 Future Developments

By their very nature, voluntary organisations must retain their identity and autonomy if they are to be fully effective as voluntary organisations. At the same time, they must work ever more closely together and in association with the statutory authorities. There is no doubt that they are aware of the need for this, and that they are prepared to meet the challenge.

12.7 Summary of Conclusions and Recommendations

1 Voluntary organisations have recognised the need for the employment of professionally trained staff. The development of their activities and services in this way, associated with their increasing co-operation and involvement with statutory bodies, helps to ensure that they will continue to have an essential role in providing services for the community (*Para. 12.4*).

2 Notwithstanding their appreciation of the need for a co-ordinated approach, voluntary organisations should regularly review their arrangements for co-ordination (*Para. 12.5*).

3 In developing their activities and services, voluntary organisations must work more closely together and in association with statutory bodies (*Para. 12.6*).

ORGANISATIONS AND INDIVIDUALS GIVING EVIDENCE

Northern Regional Hospital Board
North Eastern Regional Hospital Board
Eastern Regional Hospital Board
South Eastern Regional Hospital Board
Western Regional Hospital Board
*Miss L. Adam
*J. Bingham, Esq, FRCS
The British Medical Association (Scottish Council)
The British Association of Social Workers
The British Council for Rehabilitation of the Disabled
The British Geriatric Society (Scottish Branch)
The British Orthopaedic Association
The British Red Cross Society (Scotland)
The Chartered Society of Physiotherapy (Scottish Local Branch)
*The Department of Employment
The Disabled Living Foundation
*Miss H. Gordon
Dr B. M. Groden
*Professor Brian Jennet
W. G. Kerr, Esq, FRCS
*Miss R. E. Lane
George Murdoch, Esq, FRCS
The Late Dr A. F. Nelson
The Queen's Institute of District Nursing
*R. Rogerson, Esq
The Royal College of Nursing (Scotland)
The Royal College of General Practitioners (Scottish Council)
The Royal College of Physicians and Surgeons, Glasgow
The Royal College of Surgeons of England
The Royal College of Surgeons of Edinburgh
The Royal Medico-Psychological Association
The Scottish Association for Mental Health
The Scottish Association of Occupational Therapists

*Gave oral evidence

The Society of Occupational Medicine
The Society of Remedial Gymnasts (Scottish Branch)
*W. Sillar, Esq, FRCS
*Dr J. Simpson
Scottish Health Visitors Association
*Social Work Services Group—Scottish Home and Health Department
Professor Sir Ronald Tunbridge
University of Aberdeen (Faculty of Medicine)
University of Dundee (Faculty of Medicine)
University of Edinburgh (Faculty of Medicine)
University of Glasgow (Faculty of Medicine)

*Gave oral evidence

IMPRESSIONS OF REHABILITATION SERVICES IN SCANDINAVIA, HOLLAND AND FRANCE

I INTRODUCTION

1 Introduction

In March, 1970, a Working Party of the Sub-Committee visited certain rehabilitation centres in Europe. This report summarises the general impressions of that visit. Of necessity, it does not cover in detail every aspect of rehabilitation services covered during the visit, and in some respects it is superficial, since the programme for the visit did not allow examination in depth of the rehabilitation services in each country. These were often complex, and language difficulties also prevented fruitful discussion on some occasions. For those reasons, this report should not be regarded as an authoritative account of services abroad. In the time at our disposal, we have tried to ascertain the true position, but if our views are in any way inaccurate or misinformed, we would seek the indulgence of our readers and of our hosts abroad.

2 The Working Party

The Working Party consisted of Professor Mair, Dr Shaw, Dr Manson and the joint secretaries.

3 The Itinerary

The itinerary was as follows:

Sweden

Day 1 The National Board of Health and Welfare, Stockholm
Swedish Institute for the Handicapped, Stockholm
The National Labour Market Board, Stockholm

Day 2 Rehabilitation Clinic, Danderyds Hospital, Stockholm
National Institute for Assessment of Work Capacity of Handicapped People, Karolynska Hospital, Stockholm
Department of Social Medicine, University of Stockholm
Gymnastiske Central Institute, Stockholm

Norway

Day 3 The State Rehabilitation Institute, Oslo
Dikemark Hospital, Oslo

Denmark

Day 4 Directorate of Rehabilitation and Care, Copenhagen
The Society and Home for Cripples, Copenhagen

The Danish National Association against Infantile Paralysis, Copenhagen

Day 5 Copenhagen County Hospital, Gentofte
Copenhagen County Hospital, Glostrup

Holland

Day 6 Professor Querido—University of Amsterdam
Het Dorp, Arnhem

Day 7 De. Hoogstraat Rehabilitation Centre, Leersum
Mudierpoort Institute, Amsterdam

France

Day 8 Rehabilitation Institute, Nancy

Day 9 Vocational Training Centre, Gondreville
Children's Rehabilitation Centre, Flavigny

4 Although it was of value to see such a wide picture of the organisation of rehabilitation services, in retrospect it would have been preferable to limit the number of countries visited, and to examine rehabilitation services in one or two countries in more depth. The programmes arranged in Sweden and Denmark were excellent, but there was insufficient time in Norway, although in many ways it seemed to have most to show us, while the programmes in Holland and France were restricted in scope. The services in Norway and France seemed worthy of a deeper investigation.

II GENERAL CONCLUSIONS OF EUROPEAN VISIT

5 In assessing our visit and reaching conclusions, we were handicapped by the different methods of delivering medical services in the countries visited and the fact that the places seen were in the main those with acknowledged well-established services. Our objective was primarily to ascertain how rehabilitation services were integrated into the medical care system and their implications for medical care. Social services and sickness insurance, however, whether provided by central government or other agencies, also had a considerable influence.

6 One of the cardinal features in these rehabilitation services was the apparent capacity of the countries to achieve a high degree of co-operation between different agencies, both government and voluntary, at central and local levels. Particularly noteworthy was the substantial contribution made by voluntary organisations, including in some instances, a delegated service role. An outstanding example of this was the Swedish Institute for the Handicapped in Stockholm which had developed and evaluated a wide range of equipment and aids for the handicapped and is the accepted authority in this field through Scandinavia. In Denmark, the Society and Homes for the Crippled had assumed a responsibility for the vocational training of the

young physically handicapped. In the Netherlands NCVR (Nederlandse Centrale Vereniging ter Bevordering van de Revalidatie) a voluntary organisation, assumes overall organisational responsibility for all agencies involved in rehabilitation including rehabilitation centres, organisations of handicapped persons, homes for disabled, employment, recreation and financial support for the handicapped. In the area of Nancy in France the impetus to develop rehabilitation services had come from the Regional Agency of Social Security of the North-East which had joined forces with the Faculty of Medicine of Nancy and the Regional Hospital Centre.

7 In all the countries visited rehabilitation had been acknowledged as a specialty and programmes of work and study leading to registration established. The programmes had many similarities but were to some extent biased by the rehabilitation philosophy of the particular country, some being oriented towards psychiatry, and others towards social medicine, occupational health, and rheumatology and physical medicine.

8 Norway and France seemed to have the most balanced and comprehensive service, but generally we were impressed by a greater degree of collaboration and unification of rehabilitation oriented services within the medical services. Whereas in this country there is a considerable amount of specialisation in limited rehabilitation fields, most of the centres we visited covered a wider aspect of rehabilitation, including prosthetics and paraplegia and their whole work was very much socially and work-orientated. This arrangement appeared to us to create a much more viable and interesting specialty.

9 Another outstanding feature was the tendency in certain countries for the hard and fast boundaries between medical and industrial rehabilitation to be broken down, so that medical units included sophisticated industrial work among the activities of their programmes. Work physiology or ergonomics played an important part in the assessment of the handicapped in Scandinavia. It seemed to us that this was really a development of gymnastics which has a long tradition in these countries. Institutes of physical training have on their staff Professors of Physiology of international reputation such as Astrand at Stockholm and Asmussen in Copenhagen who have applied physiological techniques to the assessment of work capacity in the disabled far in advance of those employed in this country.

10 Another impression of our visit was the apparent recognition by central governments of the value of investment in rehabilitation programmes. Nonetheless, despite numerous enquiries, there was considerable lack of evaluation of rehabilitation services, which had been accepted as much on humanitarian as economic grounds. A number of estimates of the size of the rehabilitation problem has been made, but in no country we visited were workers in this field prepared to admit that they were meeting the needs of all despite the apparent excellence of the services we saw. The areas in which research was being executed were mainly in the development and evaluation of equipment for the handicapped, standardisation of work assessment and the rehabilitation of patients with ischaemic heart disease.

11 Though we learned about links with community services, we did not see anything of rehabilitation in relation to domiciliary care. There were considerable differences in the delivery of domiciliary medical care in the countries visited. In Sweden much of it was provided through hospital out-patient departments, and there was no clearly defined family doctor, the patient being able to approach any generalist or specialist of his choice. In Denmark a politically powerful general practitioner body has restricted the provision of hospital out-patient services. Holland is still a land of single-handed general practitioners, while in France private practice makes a major contribution to medical care. All these factors must create difficulties in achieving continuity of care so essential to rehabilitation. Perhaps we were in error in not covering this aspect of rehabilitation in planning our programme. An international reputation is more easily achieved in academic spheres and hospitals than family medicine and it is the former which visitors are shown. While hospitals may be regarded as power houses of medical treatment and research, it is only when the fruits of their labours penetrate down to health workers in the community that the maximum benefits accrue to the population as a whole.

During our visit we certainly saw active rehabilitation in practice, and met dynamic practitioners. Much of what we saw was 'like topsey and had just growed'. It was difficult to ascertain what influence it had had on other aspects of medical work. What we did learn, however, was that there was no abracadabra or open sesame, that rehabilitation would only become a viable reality when every practitioner was indoctrinated with the principles of rehabilitation as part of his basic and continuing vocational education.

III ORGANISATION OF REHABILITATION SERVICES

12 *Sweden*

(a) GENERAL ORGANISATION OF SERVICES

In Sweden, responsibility for the treatment of the sick, disabled and aged, as well as for social security schemes, is shared by the state, the counties, county boroughs and municipalities.

At a national level, policy guidance for the development of medical rehabilitation is given by the National Board of Health and Welfare.

Medical treatment is provided by the 25 counties and three county boroughs, which are divided into seven regions for the organisation of special services.

(b) DEVELOPMENT OF REHABILITATION SERVICES

Recommendations were made by the National Board of Health and Welfare in 1954 for the establishment of a hospital rehabilitation service, of a general medical character, to work in close association with vocational rehabilitation and social welfare services. This service was to be provided by the local authorities, *ie* counties and county boroughs, under the charge of a specialist in rehabilitation. Each

district hospital was to have a special department, and facilities for clinical physiology. Development of the service has been slow since then, although we undertstand that considerable expansion is planned for the future. There are continuing shortages of staff—doctors, physiotherapists, occupational therapists, social workers and technicians.

13 The majority of rehabilitation specialists work in rehabilitation centres, of which there are at present eleven in the country, each with about thirty beds, and serving a population of 200,000. It is hoped to spread these centres over the whole country. They are there essentially for long term cases. The specialist in these centres is dealing mainly with social and vocational rehabilitation and is in close contact with social welfare services and the disablement resettlement officer from the Labour Board.

In addition, there are at present five recognised departments of rehabilitation attached to hospitals and acting as a service department in the hospitals. These specialists are primarily involved in medical rehabilitation, and do not yet have a good liaison with agencies of social and vocational rehabilitation, although the disablement resettlement officer does attend the hospital weekly.

14 Vocational rehabilitation services in Sweden are very highly developed, but their links with the emergent medical rehabilitation service seemed to be tenuous. The involvement of the Disablement Resettlement Officer in the hospital organisation seemed remarkably similar to the situation in this country—difficult, inadequate and unsuccessful.

Doctors are also employed by the vocational rehabilitation service, but many are untrained. They act as consultants to the Labour Board, for medical examination of patients, and general advisers, and also supervise the sheltered workshops. Because of recruitment difficulties, most have appointments in other related fields.

15 In addition, there are a number of doctors attached to the Social Welfare Board. These are mainly psychiatrists and stem from the development of clinical social medicine, largely by Professor Inghe of Stockholm. Their work appeared to centre largely, if not entirely, on the indigent, and on social misfits.

16 In general, our impression of rehabilitation services in Sweden was that they were divided into too many different agencies, and this led to inadequate co-ordination, lack of economy in staff—particularly medical, and on occasions open rivalry between different groups.

17 *Norway*

Our programme did not include a visit to any central goverment agency, but we were informed that present plans provide for each district hospital to have a rehabilitation department, with 40 beds, facilities for physical training, one or two workshops, and a social work department. This department would provide a link from the hospital to social, vocational and educational agencies, and would be supported by special units for patients

whose vocational problems are predominant, and who require more intensive facilities. These special units are in fact medically orientated Industrial Rehabilitation Units, like the State Rehabilitation Institute. Hospital Rehabilitation services are closely associated with vocational rehabilitation, the object of both being to return patients to work.

18 In hospitals, there are both consultants in physical medicine and consultants in rehabilitation. These are separate and distinct specialties, and it was suggested to us that the existence of this division was merely a reflection of the complexity of the problem of rehabilitation. Physical medicine specialists appeared to be rheumatologists or orthopaedists, and were not concerned with work physiology, psycho-social problems or social legislation.

Rehabilitation specialists are concentrated in hospital departments, of which there are seven at present. These departments are also service departments, but enjoy good relations with colleagues in other specialties.

19 There are three vocational rehabilitation centres, which at the moment are administered by doctors. This was not seen as essential, and it was suggested that the director could come from any of the disciplines involved. In the vocational units all the components of rehabilitation—medical, social, psychological, pedagogical and vocational—are investigated in depth by the appropriate agency and a very full appraisal of the patient as a whole is made.

20 Patients undergoing rehabilitation are paid a rehabilitation allowance. This is determined by a Board under the County Medical Officer, supported by officials from the Labour Board and the social welfare department. Some doubt was cast on the value of such an allowance. Many county medical officers are also private practitioners, and it was suggested that this strengthened the link between hospital and domiciliary services.

21 *Denmark*

The Ministry of the Interior is responsible for national health services. The general hospital service is mainly the responsibility of the local authorities, although there are a few private hospitals. Few hospitals have out-patient departments. A number of large self-contained orthopaedic hospital units are run on a grant-aided basis by a voluntary institution—the Society and Home for the Crippled.

Specialists in physical medicine and rehabilitation in Denmark are all in hospital departments of medicine, and most are also rheumatologists. They do not deal in rehabilitation in any depth, and their contact with vocational rehabilitation services and social work services appeared to be slight. They also act as service departments to the hospital.

22 Although Denmark's vocational rehabilitation agencies appeared to be well organised, their contact with hospitals seemed poor. We were informed that it is their policy to keep separate medical rehabilitation and vocational rehabilitation. One's general impression of the hospital rehabilitation service was that it was limited in scope, and was virtually exercise therapy.

Future development was to be restricted to the provision of departments providing for final medical and social assessment prior to discharge, on the grounds that it is preferable for all doctors to think of rehabilitation as an aspect of total care, rather than as a separate specialty.

23 *Holland*

The overall organisation of rehabilitation services in Holland is difficult to comprehend because of the wide variety of agencies involved.

24 Long-term government policy is directed by an inter-departmental committee of officials from the departments concerned with rehabilitation. The NCVR is a private organisation which co-ordinates the work of 120 member organisations concerned with rehabilitation—rehabilitation centres, voluntary organisations for the handicapped, etc. Five of its members are appointed by the Government. In each of the eleven provinces there is a regional rehabilitation council, whose role is advisory and stimulative. These are supported by domiciliary services provided by the 'Cross Societies', and by regional advisory teams, who discuss difficult cases in each region. These teams consist of a doctor, social worker and the district nurse. All general hospitals provide rehabilitation facilities—although this appears to be limited to conventional physiotherapy and occupational therapy. Eight of these employ rehabilitation specialists, which has been a recognised specialty since 1956. There are also 22 rehabilitation centres, of which 15 have schools, or are linked to a school for physically handicapped children.

25 Patients with complex problems are referred to these centres from hospitals, and the medical staff are supported by physiotherapists, occupational therapists and social workers. The link between these centres and community services is by means of the county rehabilitation team. General practitioners have an important role in Holland, supported by social workers, and in general, one gained the impression that links between hospital and community services were quite strong.

26 *France*

Our knowledge of rehabilitation services in France is restricted to the situation in Nancy, which is almost certainly atypical, but nonetheless appeared to have a number of noteworthy features.

The Regional Institute of Rehabilitation was established in 1955 and is the result of co-operation between the regional social security agency, the regional hospital centre, and the Faculty of Medicine in the University of Nancy. The social security department is responsible for the administration of the Institute; and the university provides technical direction, in the form of Professor Pierquin, Professor of Rehabilitation. Students attend the institute for teaching purposes. All rehabilitation in the hospital is undertaken by the specialists of the Institute. The institute which serves a population of about 1 million consists of four main parts:

(a) The Hospital service;

(b) The Centre for Functional Rehabilitation at Nancy

(c) The Vocational Training Centre at Gondreville

(d) The Children's Rehabilitation Centre at Flavigny.

All centres are directed by doctors.

27 The hospital specialists control physiotherapy services and are involved in the initial rehabilitation of patients, from their admission. When necessary, patients are referred from hospital to the Nancy centre, and thence to Gondreville. Referrals to Nancy are 50 per cent from hospital, 50 per cent from general practitioners. Children are referred direct to Flavigny from hospital.

There are no difficulties in recruiting doctors to the specialty of rehabilitation. A school of Physiotherapy and a school of Occupational Therapy are associated with the Institute.

The centre at Gondreville is virtually an Industrial Rehabilitation Unit, but providing a wide range of activity including physiotherapy, pottery, workshops, welding and paint shop, gymnasia, psychological assessment and industrial assessment. It also has its own orthopaedic workshop.

28 Conclusion

The specialists in Norway appear to have a much more integrated approach than in the other two Scandinavian countries, but then it is a smaller country and possibly more easily organised. In Denmark the social component of rehabilitation appears at present to be completely divorced from medical rehabilitation and hence the specialist in Denmark is purely a specialist in physical medicine. Sweden appears to have developed a stronger social side to rehabilitation than the other countries but the impression is given that the hospitals are not yet fully co-ordinating medical rehabilitation services. This, however, appears to be recognised and attempts are being made to remedy it.

It is not possible to generalise on the situation in Holland, because of the restricted nature of our visit, although the young specialist we met in Amsterdam seemed to have an attractively broad approach to problems of rehabilitation. The activity of the 'Cross Societies' in domiciliary rehabilitation was noteworthy.

Nancy was generally impressive, because of its tightly-knit organisation. It would have been useful, however, if we could have obtained more information about rehabilitation in a hospital setting, as well as the fairly specialised work of the three centres.

IV TRAINING IN REHABILITATION

29 The training of the specialists in each country is reflected in their different outlooks. Most specialists in Sweden and Norway are neurologists or psychiatrists primarily. In Denmark they are all physical medicine and rheumatology specialists.

30 In Norway there are thirty specialists in rehabilitation. They have a five year course which includes a compulsory year of psychiatry, a year in internal medicine, work physiology or research, a course of principles of social legislation and a course of work physiology (if not carried out before) and finally a period attached to a hospital department or a vocational unit. It is hoped to double the number of such specialists in the next few years.

31 In Sweden there are four accredited specialists at present and a number in training. Specialist registration in rehabilitation was only introduced in 1969. The Swedish Society of Rehabilitation Medicine, however, has 52 members, most of whom are chief physicians or assistant chief physicians, and who have worked in rehabilitation departments for some time. Training consists of three years in a clinic or hospital department of rehabilitation. Of this up to six months is spent in a neurological or orthopaedic clinic. There is a further year in internal medicine, up to six months of which is in a department for long term care of patients and six months of psychiatry. It is hoped to expand the specialty over the next ten to fifteen years to about 150 specialists and 150 trainees.

32 In Denmark there are 85-90 specialists in physical medicine and rehabilitation and it is hoped to double this figure in the next five to ten years. Their specialist training consists of six months in neurology or one year in neuro-surgery, six months in orthopaedics, one year of general medicine, surgery or one year in some work of their own choosing, with finally two years as an assistant in a department of physical medicine and rehabilitation. Further development of specialty training in physical medicine was seen as an extension of physical medicine into scientific rheumatology, and into more general rehabilitation, *ie* a division of the specialty into two areas.

33 In Holland, training in rehabilitation lasts for four years, and comprises one year of rheumatology, either in a rheumatological clinic, or in an internal medicine clinic with a large rheumatological caseload, two years in a general rehabilitation centre for children and adults, one year in an out-patient rehabilitation centre, or combinations of these.

34 In France, in all medical faculties, undergraduate students receive 15/20 hours teaching in rehabilitation in their 5th year. Specialist training is provided by a comprehensive course of three years, details of which we were unable to obtain, except that it contains social psychology. Once qualified, doctors can specialise in rehabilitation centres like Nancy, of which there are about 50 in France, 15 of which are very large, or they can enter private practice.

V VOCATIONAL REHABILITATION

35 *Sweden*

The Swedish National Labour Market Board, which is a government agency under the Ministry of the Interior, Labour and Housing, is responsible for the supervision of regional and local employment services, and the work

of the county labour boards. It has a special division for dealing with problems of handicap.

Sweden has borrowed heavily from United Kingdom concepts, and has a DRO service based on county labour boards and branch officers. There is, however, no registration of disabled workers, nor designated employment.

A number of special schemes has been devised for the handicapped, including archive work, semi-sheltered employment in special departments in industry, and work camps, which give outdoor work for alcoholics, drug addicts, delinquents and long-term unemployed. Each county has an industrial rehabilitation unit, with extensive assessment facilities. Sheltered workshops, which are run by the counties and municipalities, are extensively provided, there being 275 workshops, with 11,000 places, including 15 special workshops for the mentally retarded.

36 *Norway*

Our itinerary in Norway did not include the Labour Board and consequently it is not possible to provide an accurate or detailed picture of their services. As we understand it, rehabilitation departments are to be established in hospitals with one or two workshops, etc. Where necessary, patients are referred to special centres such as the State Rehabilitation Institute, where greater emphasis can be given to the vocational aspects of rehabilitation. Such a closely integrated organisation is probably influenced by geography and population distribution. In the psychiatric hospitals, too, work therapy appears to be fairly highly developed, and this is supported by community developments.

Sheltered workshops are provided by the Ministry of Labour. Applicants for sickness insurance, and other forms of social assistance can be obliged to have an examination by the County Medical Officer, a social worker and the County Rehabilitation Officer for the handicapped.

37 *Denmark*

In Denmark, there is a county-wide net of rehabilitation offices. These are primarily counselling and co-ordinating bodies, and are responsible for arranging vocational training. These offices all have medical officers whose duties are wholly administrative. Their contact with hospitals is variable. They may refer clients for occupational rehabilitation to schools, industries, or to special rehabilitation units, and may arrange for medical, physiological and psychological examination.

Referrals to these centres were from the following sources:

General Practitioners	—	26 per cent
Hospitals	—	10 per cent
Psychiatric Hospitals	—	4 per cent
Ministry of Labour Municipal Authorities Own initiative	—	60 per cent

Vocational retraining is provided by 35 Industrial Rehabilitation Units; 7 special medico-occupational centres; and sheltered workshops.

The industrial rehabilitation units do not have full-time medical cover. Most are independent institutions run on a grant-aided basis; some are local authority institutions, and these also receive a government subsidy.

The medico-occupational centres, which have a total capacity of 500 places, provide a service for patients requiring work retraining under medical guidance.

Co-ordination of medical and occupational rehabilitation appeared to be a real problem in Denmark. Medico-occupational centres had difficulty in attracting staff, and appeared to have uncertain relationships with hospitals and other organisations. We were informed that the trend was to provide a medical rehabilitation service in hospitals, separate and distinct from vocational training centres, which would be run by technical officers, with medical staff in attendance on a part-time basis. The hospital rehabilitation service, however, is at present heavily orientated towards physical medicine, as described in Chapter III.

38 *Holland*

Disabled persons can attend adult vocational training centres, and may be referred there by Disablement Resettlement Officers. We understand the extent of medical involvement in these centres to be minimal. Medical rehabilitation seemed to be centred on the twenty rehabilitation centres.

There are 180 sheltered workshops, with places for 40,000 workers, and offering a variety of types of employment, including clerical work and out-door work. One rehabilitation centre which we visited—Mudierpoort—which was the only one of its type in Holland, had a wide range of heavy engineering equipment and was in the process of developing ergonomic studies, and a programme of research into medical rehabilitation.

39 *France* (*Nancy Area*)

The situation in Nancy may not be typical of that pertaining in the rest of France, but the organisation and integration of medical and industrial rehabilitation was interesting. This is described more fully in Chapter II. The centre at Gondreville was very similar in many respects to an IRU, except that it was run under close medical supervision, by staff associated with the main centre in Nancy. The centre provides:

Functional adaptation by professional training;

Five different workshops;

A gymnastic department.

The latter provides a series of graded exercises based on individual assessment of capacity. The French equivalent of a DRO is employed at the centre.

VI LINES OF COMMUNICATION

40 Whether it concerns a patient requiring rehabilitation on discharge from hospital, or by contrast, to initiate within the community the necessary stimulus to obtain further medical or industrial rehabilitation, then the mechanism which brings this about (or fails to do so) is important.

Perhaps, with the possible exception of Norway (but here the visit was too short for firm opinions to be formed) the lines of communication in rehabilitation in European countries are not convincing. As in the United Kingdom, this difficulty derives from various attitudes, either in the pattern of medical care to individuals, or the compartmental division which legislation under different ministries brings about.

41 In Sweden, like the USA, the choice of physician is universal. Patients may have several physicians of first contact. Doctors operate from the hospital into the community and vice versa. Links in such a situation must be tenuous. Yet, they seemed increasingly concerned with those patients who are still on social insurance for a period of '90' days and require medical and/or vocational assessment. One had no clear and convincing evidence that the system provided for comprehensive follow-up.

42 In Norway, it appeared that two-way communication operated most satisfactorily and listening to the philosophy of Dr Harlem, one was convinced that it worked.

43 The lines of communication in Denmark seemed unsatisfactory. In the two Copenhagen county hospitals, there were, for historical and medico-political reasons, no out-patient departments as such. Patients discharged might reach Rehabilitation Centres (not in a physical but in a Committee or administrative sense). Here, decisions are taken to send the patient for vocational rehabilitation or not. The DRO does not visit the Hospital (Glostrup) and the Rehabilitation Specialist or his assistant do not sit on the Rehabilitation Centres (Committees). Social Workers assist in the rehabilitation process, but seemed to be concentrated more in non-hospital agencies.

44 In Holland, we were informed that it is hoped that the renaissance in general practice might well produce the necessary two way form of communication which is often necessary in complex cases of rehabilitation. Although our visit was too brief to make firm statements the general impression of services in Holland was that lines of communication were fairly strong, but whether this was due to county rehabilitation teams or other means is impossible to say, because of the confusing organisation of services generally in the country.

VII MEDICAL EDUCATION AND RELATIONSHIPS WITH UNIVERSITIES

45 We asked in each country how medical students were introduced to the concept of rehabilitation. Nowhere was this described as completely satisfactory. In Scandinavia it was usually in the hands of Professors of Social Medicine whose interest in the subject was variable. Most of those asked felt it should be introduced at the clinical level but nobody had a clear idea how this break-through might be achieved. There is one Professor of Rehabilitation in Sweden—at Gothenberg—a chair based, so far as we could determine, on the enthusiasm of the incumbent. We got no information about further chairs likely to be developed in Sweden at the present. In

Norway, there is the possibility that the three large rehabilitation institutes in Oslo, Bergen and Trondheim, may be developed into University departments with Professors at their head and to teach medical students. At present, students only have one day in the institute as part of a three-week series of visits in the Social Medicine course. In Denmark three chairs of Physical Medicine and Rehabilitation are also in prospect but it is likely that they will have a strong physical medicine bias, to start with at least.

46 We came away with the impression that in all these countries the personnel in rehabilitation would like to see the subject incorporated into medical thought at all levels but that this was a slow process which might be hastened by the appointment of chairs and the improvement of research. None of the possible candidates felt himself adequately trained for the post of professor and it would obviously be awarded on a basis of personal enthusiasm and drive, candidates sometimes coming from social medicine and sometimes from physical medicine.

47 In Holland, our information came chiefly from Professor Querido, a retired Professor of Social Medicine of international standing who was much interested in the subject of rehabilitation, particularly from the psychosocial aspects. The Mudierpoort Centre is associated with the City University of Amsterdam, and a special chair of rehabilitation medicine has been created. There are two lecturers (without any centre or beds), one at the Free University in Amsterdam, and one in Groningen who worked in Rehabilitation Centres near the University centres, although not part of it. In Utrecht and Leyden there are also two University lecturers in Rehabilitation. Professor Querido was less concerned about the title than that the individual should be an enthusiast getting good results which impressed his clinical colleagues; in this way he thought rehabilitation would steadily gain respect and status among general physicians and surgeons.

48 In France, our information came from Professor Pierquin, himself occupying the chair of Rehabilitation and Occupational Medicine at Nancy, as well as being director of the Nancy Centre for Rehabilitation. He felt that a University association was most important in improving the status of the subject generally. In Paris there exists the only Chair of Rehabilitation, which is the title that Professor Pierquin prefers; elsewhere, in all the medical faculties in France, there are chairs of occupational medicine and some of these combine rehabilitation; alternatively, rehabilitation is added to other chairs, *eg* traumatology, rheumatology, etc. but this is less satisfactory. Since 1965 in France (1954 in Nancy) all medical students must have 15 hours instruction in theory and clinical practice of rehabilitation medicine in the fifth year of studies. Professor Pierquin attributed the success of his institute to: (a) Available money; (b) Good Staff; (c) Good co-operation between doctors and lay administration (provided by the Trade Unions); (d) Academic influence.

VIII AIDS AND APPLIANCES

49 By far the most impressive arrangement for dealing with aids for the handicapped was seen in Sweden, in the Swedish Institute for the

Handicapped. Formed by joint action by the Government and the Swedish Central Committee for Rehabilitation, the aims and objects of the Institute cannot be better summarised than in the following excerpt from the Bill to Parliament which established the Institute:

> I will not deny that it is of value that research and development work about the same project is carried out from several quarters and by different research people and institutions. Such research concerning solutions of the same problems will often lead to successful results. This goes especially for basic research which is free with regard to topic and methods. However, when it is a question of a specialised activity directed at constructing and developing efficient aids for the handicapped, the present system does not function entirely satisfactorily.
>
> Therefore the Swedish Institute for the Handicapped should have an important co-ordination task in setting up a program for research and developing work in the field of aids. The institute shall assist in spreading the activities in a better way to projects for various kinds of handicapped persons. As a central co-ordinating institute it should be in the position of giving priority to certain projects and to stimulate those activities which are most important. The institute should also see to it that the findings of research and development work result in practical projects. By analysing the needs of the handicapped for various kinds of aids the institute should provide firms and other interested parties with competent advice making possible manufacturing and marketing.
>
> This task of the institute is of utmost importance as the production of special aids to the handicapped often is made only in limited series.
>
> It is also important that the information be directed at all those who are engaged in or depend on the activities. The information should therefore concern details about completed or planned projects as well as those going on and it should indicate the results reached and the methods used. The institute should be a documentation and information centre for such questions. Beginning with the research and development program which it shall establish, it shall furthermore put out information about the need for projects with certain aims. This information should, as I mentioned before, contain details about the results of testing and evaluation of aids. Finally, I would stress the importance of the training of personnel within the field of technical aids.

50 A list of approved prescribable aids is published by the National Health Board and is issued to all health service workers. All items on the list follow recommendations by the Institute, which is responsible for testing and approving all items on this list. The relative limits of prescribing authority, which extends to nurses, physiotherapists and occupational therapists, are set down in this list.

Briefly, the activities of the Institute are as follows:

(i) EVALUATION

This is undertaken by a team consisting of a doctor, engineers, occupational therapists, a sociologist and psychologist. At the time of our visit, priority was being given to the evaluation of 400

products considered suitable for inclusion on the prescribers list, This evaluation included studies of literature, and clinical and user opinion. A technical test programme is prepared, based on user requirements, the environment, etc, and technical testing is carried out in testing laboratories. A functional test programme is prepared and the equipment is then tested in hospitals and clinics, with support from the Institute. In this way, not only is equipment assessed properly, but clinicians and others are brought into the evaluation process, and their knowledge of current developments is extended.

In the evaluation of aids, use is also made of Consumers Association and State Consumer Institutes. Some of the testing in the Institute has been carried out in co-operation with RICA (London).

(ii) EDUCATION

Not only does the Institute seek to involve field workers in its evaluation of equipment, but it also runs courses and conferences for nurses, occupational therapists, managers and supervisors of Industrial Rehabilitation Units, and sheltered workshops.

(iii) INFORMATION

The Institute acts as a central point for the dissemination of information about equipment, services for the disabled, etc. This extends to all levels, both user and prescribers. Use is made of wireless and TV advertising, to indicate which equipment has been tested.
There is a permanent exhibition of aids and gadgets.

(iv) PRODUCTION

There is no direct involvement in production, but the Institute acts as a link with industry, both in the development and production of aids and appliances.

(v) RESEARCH AND DEVELOPMENT

The Institute is deeply involved in programmes of technical research, in prosthesis, lifting apparatus, wheelchairs etc. This is supported by need analyses, mainly aimed at prosthetics.

(vi) UTILISATION

Attempts are made to survey and assess the utilisation of prescribed aids, and to feedback results.

51 No comparable organisation to the Swedish Institute for the Handicapped was seen, and in fact the other Scandinavian countries make use of its services. In all countries, however, there seemed to be a greater awareness of the need for clear guidance on the range of aids available, on where they could be obtained etc. The Danes publish an illustrated catalogue of prescribable aids for daily living, and also seek to disseminate information centrally, by means of the press, radio, TV, professional journals, circulars etc.

52 In Holland, three voluntary organisations and the Nederlandse Centrale Vereniging ter bevordering van de Revalidatie (NCVR) were responsible for an interesting new development, *viz* the Stichting Technische Voorlichting

ten behoeve van Lichamelijk Gehandicapten (Foundation for Technical Information on behalf of the Physically Handicapped), which gives information in the field of technical rehabilitation of physically handicapped persons. They collect and follow up information in the field of appliances, means of transportation, handicapped housewives, adaptation of instruments, etc. and pass their knowledge and experience on by means of pamphlets, lectures and occasional exhibitions.

53 Motor Vehicles

An impressive aspect of the service in Denmark was the arrangements for the provision of motor vehicles for the disabled. Cars are provided not only if required to enable people to go to work, but also if required for social reasons. Purchase Tax exemption is given according to the degree of disability, and the balance is given in the form of an interest-free loan. There are no defined standards of eligibility, and each patient is assessed on the basis of his medical and social situation, by a standing board. Any make of car can be chosen, according to the client's ability to meet repayments, and we were informed that approximately 1,000 vehicles per annum were supplied.

In Sweden, Government grants are available for the purchase of a motor car to the value of the cost of a motor powered invalid tricycle, provided the car is purchased after a tricycle has been prescribed. Grants and loans for the purchase of motor vehicles are also provided by the National Labour Market Board (DEP) when a car is required to enable people to earn a living or to participate in vocational training. The grant corresponds to the net cost of the vehicle, up to a value of 15,000 Swedish Kroner. Above a certain income level, the grant is reduced progressively up to an income limit.

54 Housing

(a) *Denmark*

The suitability of a flat for handicapped persons of little mobility is, as a general rule, the result of a special design. The disabled persons' own organisations as well as certain private developers, however, now recommend that all ground-floor flats and flats with a lift shall normally be so designed as to render the flat fit for the physically handicapped.

55 In order to facilitate daily housework, flats have been laid out for the handicapped in a few blocks of service flats, *ie* apartment houses with cafeteria, restaurant, caretaker service, hobby room, cleaning service, etc. The flats are so arranged and equipped as to meet the needs of persons who are unable to move about, and home helpers may be attached to the houses. It is considered important that some of the tenants are non-handicapped persons. Blocks of service flats for disabled people have been erected in Copenhagen and Alborg. Similar houses are being planned at Esbjerg, Abenra, Arhus, Naestved and Frederiksberg, and five or six other towns have similar plans under consideration.

56 The lay-out of blocks of service flats is based on experience gained from existing houses and, for example, on an experiment made through the fitting up of so-called 'sheltered flats' in a block of service flats in Copenhagen. In that house, a few big flats suitable for wheelchair patients were made available to some young, severely disabled persons who otherwise would have had to be maintained in a nursing home. Each of them has now his own room in groups of three, four or five in self-contained flats and are able to manage by themselves with a home helper for cleaning, bathing, etc, and with facilities for meals at the restaurant of the house. Encouraged by the success of this experiment, ordinary flats in blocks of service flats have later been let to people just as handicapped as those occupying the 'sheltered flats'.

57 A service combining family care with institutional care has been provided in the block of service flats in Copenhagen for a small, but severely afflicted group of handicapped, *viz* polio patients suffering from respiratory paralysis who require a respirator and are in need of constant care and attention by day and night. The patients live with their family in specially adapted flats. On the top floor of the building there is a nursing department with professional staff and equipment, livingrooms, etc, where the patients may stay during the night or if, because of illness, holiday or otherwise, their people are unable to look after them. This department also accommodates a number of patients who cannot stay in their own homes.

58 With a view to safeguarding the housing interests of the handicapped a Housing Committee for the physically handicapped has been set up by a number of voluntary organisations; the objective of the Committee is to inquire into the housing needs of the physically handicapped, to consult with public authorities on the housing problems of handicapped people, to prepare standard designs of houses for the physically disabled, including standard designs of kitchens for disabled housewives, and to provide guidance to building societies and individual persons who intend to build houses specially designed for the physically handicapped.

(b) *Holland*

59 A comprehensive report, translated into English under the title *Housing for the Disabled,* drawn up in 1960 under the auspices of the NCVR has induced the Ministry for Housing to create facilities for builders of new houses for the disabled, or for the adaptation of existent houses.

Gradually, 'homes' are being erected in various parts of the country to house disabled adults, who are unfit for independent living, or who cannot be cared for at home. A report regarding appropriate location, furnishing, appliances, personnel, etc, has been drawn up.

The scheme for a 'village' has materialised in the eastern part of the country for the housing of severely disabled persons, unfit for independent work in normal surroundings.

IX RESEARCH

60 In every centre we have enquired about current research into techniques, equipment, cost effectiveness. On the whole we have been struck by the general lack of available information at the present time.
The Scandinavian countries appeared to have made serious attempts to assess their needs in the rehabilitation field and to have reasonable future planning. Norway appeared to us the most co-ordinated in this respect. Holland and France, in so far as we had any overall picture, had less well defined future plans, but some work of this type was in progress at Mudierpoort.

61 We found little or no evidence of serious cost-effectiveness studies although admittedly these are not easy to plan. Some institutes had worked out their daily nursing costs in comparison with hospital costs. For example, at 145 Kr. daily the Polio Institute in Copenhagen cost about half the daily hospital charge; in the Physical Medicine Department at Gentofte it costs 60 Kr. daily in comparison with 425 Kr. in a general hospital bed. In the handicapped village of Het Dorp in Holland the cost is 52 G. daily. Apart from these figures we also had the usual statistics in terms of through put, duration of stay, source of referral, etc, which, while of interest, hardly count as research. France, as represented by Nancy, frankly admitted they had no evaluation studies but claimed that 75 per cent of their patients took up their original work; the cost of their institute is 100 fr. per patient per day, compared with 130 fr. in a general hospital.

62 With regard to treatment evaluation, everyone spoke of the need for this and of the difficulties. Dr Harlem (Oslo), Dr Bjerner (Stockholm), Professor Inghe (Stockholm) all have long-term prospective studies in operation and although we did not visit him we understand this is also true of Professor Höök in Gothenburg. Where rehabilitation was more based on physical medicine as in Denmark, we found no evidence of widely based studies. Again, at Mudierpoort, in Amsterdam, the need for this kind of work has been appreciated and follow-up studies are in progress to check on efficiency.

63 It is interesting to note, however, the awakening of interest in rehabilitation among the internists and in particular the cardiologists. In centres where cardiologists are taking up exercise programmes in the treatment of their patients there is almost always evidence of a controlled trial in existence. Unfortunately in most countries these trials are fragmentary although often carried out by distinguished cardiologists, Exceptions are probably the works of Astrand at the Karolinska and Tiblin at Gothenberg. It is a problem now to achieve satisfactory numbers of controls since so many cardiologists advocate greater activity in all their post-infarction patients. Therefore, the 5-centre trial described in Holland is of great interest and should produce valuable results. It is fortunate that basic research work on techniques has already been extensively carried out, largely by Astrand in Sweden; and also we were most impressed by the work assessment studies of Asmussen and Marlbeck in the Polio Institute in Copenhagen. These studies will greatly facilitate the work of future research.

64 Another impressive area of research was the study and evaluation of equipment being carried out by the Swedish Institute for the Handicapped (largely by a British engineer and to some extent in co-operation with British test institutes) resulting in the production of a most valuable list of aids.

X ACCOMMODATION

65 There was no clear pattern of providing accommodation for rehabilitation departments in any of the countries we visited. Centres could be attached to hospitals, or could be separate buildings with no direct association with a hospital. There were advantages and disadvantages in both forms of organisation. Association with a hospital meant access to physiological laboratory support, access to other supporting services, and close clinical associations with other specialties. On the other hand, rehabilitation centres require a different milieu from that of a hospital—the tempo is different, attitudes are different, and facilities required are rather different.

There would seem to be merit in a compromise solution, providing separate rehabilitation centres, in reasonable proximity to district general hospitals. Such a centre could have functional links with the hospital, rather on the lines of the arrangements at Nancy where there seemed to be a clear flow process from hospital to the different components of the rehabilitation centre.

On the basis of the centres we visited, the accommodation in a rehabilitation centre should include:

Hostel accommodation
Physiotherapy Department
Occupational Therapy
Gymnasia—indoor and outdoor
A variety of workshops
A household flat
An office training unit
Hydrotherapy
Office accommodation for social workers, psychologists, etc.
Lecture rooms

The centres we visited were housed in both old and new buildings, and one obvious lesson was that it is not the quality of accommodation which determines the success of a rehabilitation department, but the energy and enthusiasm with which it is run.

LEGISLATION AFFECTING REHABILITATION SERVICES

1 Disabled Persons (Employment) Act, 1944 and 1958
2 Scottish Education Act, 1946, 1962 and 1969
3 National Insurance Act, 1946 *et seq*
4 National Insurance (Industrial Injuries) Act, 1946 *et seq*
5 National Health Service (Scotland) Act, 1947
6 National Assistance Act, 1948
7 Mental Health (Scotland) Act, 1960
8 Health Services and Public Health Act, 1968
9 Social Work (Scotland) Act, 1968
10 Chronically Sick and Disabled Persons Act, 1970

THE INDUSTRIAL REHABILITATION SERVICES OF THE DEPARTMENT OF EMPLOYMENT

1 Although the industrial rehabilitation service of the Department of Employment is being increasingly used as an instrument of manpower policy, it originated largely as a social measure, from the recommendations of the Tomlinson Committee on resettlement of disabled persons in 1943 (Cmnd 6415). Statutory provision for it was embodied in the Disabled Persons (Employment) Act, 1944. The Piercy Committee, which reviewed and confirmed its role in the arrangements for resettling disabled people in employment, saw it still largely as a social service.

Purpose of the Service

2 The industrial rehabilitation service is designed to operate, not as an independent service, but as a fractional part of the total rehabilitation and resettlement service, which is itself a part of the general employment services provided by the Department through its network of about 900 employment exchanges throughout Great Britain. (114 in Scotland).

3 The service aims to provide a nation-wide facility for short courses, with syllabus arranged to meet the individual's need, in simulated industrial conditions in Industrial Rehabilitation Units (IRUs). There are at present four such IRUs in Scotland, which give local coverage to the more populous parts of the country. Some IRU entrants live too far away from their local IRU, however, to travel daily, and they are accommodated either in lodgings or in the residential hostel which is attached to Edinburgh IRU.

4 The IRUs do not provide training in skill; they seek to restore a person's confidence after injury or long illness, and they give him an opportunity to become accustomed gradually to the mental and physical requirements of a full day's work and the demands of industrial discipline. During his IRU course a person receives skilled vocational guidance; there are psychological tests of his occupational aptitudes, and he is employed on production work which provides opportunities for practical assessment of his capacity and potential in a variety of working environments so that he can be guided towards the kind of work to which he is best suited. Often the IRU's assessment leads to a recommendation for skilled training. For the majority of people, however, the assessment enables the Department's employment services to introduce them to employers with confidence that the men and the jobs have been sensibly matched, and the people to some extent prepared for the employer's requirements.

Clientele and Recruitment Problems

5 Many entrants to IRUs have been recently sick or are recovering from injury. Well over half of them are referred by the medical services working closely with the Department's Disablement Resettlement Officers; the aim is that rehabilitation and preparation for resettlement should be a continuous process with the emphasis in the beginning on the medical aspect and with employment as the final goal. In the IRUs, which are not medically orientated, the object is a short 'topping-off' course during which the 'patient' becomes a worker. The duration of courses is usually 6, 7 and 8 weeks, but they can last longer, up to a normal maximum of 12 weeks, with extension in exceptional cases up to 26 weeks.

6 The service is available to anyone, male or female, over school-leaving age who needs a course, is likely to benefit from it and intends afterwards to engage in work in Great Britain. There is no upper age limit, but in practice very few people enter IRUs who are aged 60 and over. About 13 per cent of entrants in Scotland are women. The IRUs cater for all types of disabled people except the blind, for whom there are separate arrangements. There is no segregation within the IRUs by disability, sex or age, and some considerable benefit is regarded as accruing from this mixing of disabilities in the same industrial milieu. Many of the people entering IRUs would have benefited from earlier reference by the medical services. All IRUs in Scotland are attached to and work in close conjunction with Government Training Centres. This arrangement produces operational advantages such as co-operation on production work, better total range of assessment facilities, more 'industrial' atmosphere etc. For people on IRU courses the same general conditions about maintenance allowances etc. apply as to trainees at GTCs, except that the scale of maintenance allowances is fractionally lower. The allowances whilst on the course replace unemployment and sickness benefits which would normally be in payment if the individual was not undergoing rehabilitation, but if the circumstances warrant it supplementary and hardship allowances from the Department of Health and Social Security may continue in addition.

APPENDIX V

Diagnosis	Discharges		Bed Days		Mean Stay		Discharges per million pop.		Beds Used per million pop.		Diagnosis
	1961	1968	1961	1968	1961	1968	1961	1968	1961	1968	
Diseases of Nervous System and Sense Organs	21,817	29,526	686,302	677,631	32	23	4,195	5,684	362	357	
Diseases of Circulatory System	48,274	64,149	1,974,534	2,336,003	41	36	9,283	12,349	1,040	1,232	
Diseases of Bones and Organs of Movement	24,072	28,228	709,254	685,821	30	24	4,629	5,434	373	361	Diseases of Connective Tissues and Musculo-Skeletal System
Diseases of Respiratory System	63,425	64,413	830,352	1,177,298	13	18	12,197	12,400	437	621	

Source: Scottish Hospital In-Patient Statistics, 1961, 1969; Scottish Home and Health Department

AN OUTLINE TRAINING PROGRAMME IN MEDICAL REHABILITATION

1 Specialist training in rehabilitation would commence after completion of the recommended three years general training after registration. This general training should normally be in General Medicine, although there is no reason why doctors with a surgical background might not prove equally suitable candidates. Some experience of neurology, in addition to general medicine, and of orthopaedics and trauma in addition to general surgery would, at this stage, be valuable. The possession of a higher qualification would be essential.

2 Specialist training, which would normally be of four years duration, should cover the following areas:

(a) *Applied Physiology and Anatomy*

This would normally be provided by short-term appointments to a University Department. A sound knowledge of applied physiology and functional anatomy is essential, with particular reference to physical activity and its place in rehabilitation, but also with reference to its use in maintaining the physical fitness of all members of the community, including school children, adolescents and adults. Study of the training methods of colleges of physical education would be useful. Because of the limited numbers involved, it would seem to be desirable to make arrangements with one University Department to provide facilities for all candidates from Scotland.

(b) *Research Methods, Epidemiology and Statistics*

An understanding of the application of scientific methods in assessing rehabilitation measures is necessary, and training in this field should include work in epidemiological methods, in statistical analysis, computer techniques, medical records, the social and economic aspects of morbidity, utilisation of regional services, etc.

(c) *Psychiatry*

The methods of psychiatric and clinical psychological assessment will require to be understood in some detail. In view of the psychological and social repercussions of serious injury or illness and the reactions of the vulnerable personality to such stress, the trainee should have a continuing association with psychiatric practice during training.

(d) *Methods of Medical Rehabilitation*

Training should include experience and assessment of the methods of medical rehabilitation used in hospital wards, departments of rehabili-

tation and health centres. Particular attention should be paid to medical rehabilitation in units for the treatment of geriatric patients, patients with spinal injuries and head injuries and in limb fitting centres.

(e) *Industrial Rehabilitation*

Field work in industry should be undertaken, and detailed understanding of the work of Industrial Rehabilitation Units and Government Training Centres obtained.

(f) *Community Services*

With the development of primary medical care, the trainee should obtain experience in the work of the general practitioner, and obtain practical knowledge of community services, including social work, school health, and voluntary services, and of the structure and functions of all agencies, statutory and voluntary, medical and non-medical, which are concerned with rehabilitation.

3 This training would normally be undertaken at Senior Registrar grade, and the trainee would be attached to the Department of Rehabilitation in a teaching hospital. In deciding upon a programme of training, there would have to be considerable flexibility. It would be essential to ensure that at all times the trainees was able both to sustain interest in the work of the departments in which he was working, and to play a responsible part in the work of that department. In the final year of training, the trainee might be required to carry out a research project, on a selected subject in medical rehabilitation. The presentation of such a project would permit a full appraisal of the trainee's potential for advancement to be made.

PERSONS EMPLOYED IN HOSPITAL REHABILITATION SERVICES IN SCOTLAND AT 30 SEPTEMBER 1958, 1963 and 1968

		1958	1963	1968
Physiotherapists	FT	457	471	516
	PT	98	98	194
	Total	555	569	710
	WTE	506	522	600
Remedial Gymnasts	FT	18	21	25
	PT	3	3	1
	Total	21	24	26
	WTE	19	23	26
Occupational Therapists	FT	148	157	207
	PT	13	11	30
	Total	161	168	237
	WTE	154	164	225
Speech Therapists	FT	5	12	21
	PT	12	10	8
	Total	17	22	29
	WTE	11	17	24
Medical Social Workers	FT	90	94	102
	PT	12	17	37
	Total	102	111	139
	WTE	96	106	121
Psychiatric Social Workers	FT	36	57	62
	PT	2	5	13
	Total	38	62	75
	WTE	37	60	70

Manpower Planning Branch
August 1971

Source HS8

Abbreviations:
FT = Full-time
PT = Part-time
WTE = Whole-time equivalent

BIBLIOGRAPHY AND REFERENCES

1 Report of the Inter-Departmental Committee on the Rehabilitation and Resettlement of Disabled Persons. (Tomlinson Report). Cmnd 6415. HMSO 1943.

2 Department of Health and Social Security. Report of the Working Party on Comprehensive Assessment Centres for Handicapped Children. (Sheldon Report). 1968.

3 Scottish Home and Health Department. Reorganisation of the Scottish Health Services. Cmnd 4734. HMSO 1971.

4 The Rehabilitation, Training and Resettlement of Disabled Persons. (Piercy Report). Cmnd 9883. HMSO 1956.

5 Nuffield Provincial Hospitals Trust. 'Hostels' in Hospitals? London. Oxford University Press. 1968.

6 Report of Working Party on Rehabilitation—South-Eastern Regional Hospital Board, 1962.

7 Review of Rehabilitation Services—Eastern Regional Hospital Board, 1967.

8 Nuffield Provincial Hospitals Trust. Hospital and Community. London, 1954.

9 Nuffield Provincial Hospitals Trust. Further Studies in Hospital and Community. London, 1962.

10 Bennett, A. E. *et al:* Chronic Disease and Disability in the Community. BMJ 1970, 3, 762-764.

11 Rankine, R. & Weir, R. M. L.: Enquiry into the Incidence of Chronic Illness and Disability in the Young and Middle-Aged. 1967.

12 Royal Commission on Medical Education. (Todd Report). Cmnd 3569. HMSO 1968.

13 Scottish Home and Health Department. The Medical Care of Epilepsy in Scotland. (Hutchison Report). HMSO 1968.

14 Scottish Home and Health Department. The Young Chronic Sick. (MacDonald Report). HMSO 1964.

15 Scottish Home and Health Department. The Future of the Artificial Limb Service in Scotland. (Denny Report). HMSO 1970.

16 British Medical Association. Aids for the Disabled. Planning Unit Report No. 2, BMA 1968.

17 Report of the Standing Committee on the Rehabilitation and Resettlement of Disabled Persons. HMSO 1946.

18 Rehabilitation—Report of the Sub-Committee of the Standing Medical Advisory Committee. (Cathcart Report). HMSO 1947.

19 Second Report of the Standing Committee on the Rehabilitation and Resettlement of Disabled Persons. HMSO 1949.

20 Scottish Hospital Memorandum SHM 58/54—Rehabilitation.

21 World Health Organization. First Report of the WHO Expert Committee on Rehabilitation. WHO Technical Report Series No. 158, 1958.

22 Third Report of the Standing Committee on the Rehabilitation and Resettlement of Disabled Persons. HMSO 1958.

23 Executive Council Memorandum ECS (M) 174/1960—Rehabilitation of the Sick and Injured.

24 Final Report of Ad Hoc Committee on Rehabilitation—Sheffield Regional Hospital Board, 1962.

25 Scottish Hospital Memorandum SHM 61/1966—Report of Working Party on Industrial Rehabilitation/Review of Liaison Arrangements.

26 The Place of Medical Rehabilitation in the Organisation of Health Services. WHO Strasbourg 1967. HMSO.

27 Report and Recommendations of Remedial Professions Committee of the Council for Professions Supplementary to Medicine. London 1970.

28 World Health Organization. Second Report of the WHO Expert Committee on Rehabilitation. WHO Technical Report Series No. 419, 1969.

29 Yates, Gordon.: Services for the Disabled—A report to the Nuffield Foundation.

30 Martin, M.: Colleagues or Competitors. Published by G. Bell & Sons, London.

31 Report of the Working Group on Services for the Physically Handicapped and Rehabilitation. Department of Health and Welfare, Buckingham County Council, Aylesbury, Bucks.

Printed in Scotland for Her Majesty's Stationery Office by John McQueen & Son Ltd., Galashiels
Dd 259710/3070 K24 5/72

Three earlier reports from the Scottish Health Services Council

Dental Services in Health Centres

The Report of a Committee to consider the future role of dentistry in health centres to ensure that any such development will be in the best interests of the patient and the future of dental science.

15p net (18½p by post)

Forensic Psychiatry

The Report of a Committee appointed to consider the provision and development of psychiatric services required; to furnish the courts with the assistance requested by them in deciding the disposal of offenders; to assist other services responsible for the treatment of such persons; and to treat persons referred by those services or by the courts.

27½p net (31p by post)

Uses and Dangers of Oxygen Therapy

A Study of oxygen therapy including adult hospital practice, domiciliary practice, obstetric practice, paediatric practice, air travel, resuscitation, industrial practice, treatment of drowning and apparatus for oxygen administration.

47½p net (54p by post)

Obtainable from GOVERNMENT BOOKSHOPS

in Edinburgh, London, Manchester, Birmingham, Cardiff, Bristol and Belfast, or through booksellers.

Her Majesty's Stationery Office

Government Bookshops

13a Castle Street, Edinburgh EH2 3AR
49 High Holborn, London WC1V 6HB
109 St Mary Street, Cardiff CF1 1JW
Brazennose Street, Manchester M60 8AS
50 Fairfax Street, Bristol BS1 3DE
258 Broad Street, Birmingham B1 2HE
80 Chichester Street, Belfast BT1 4JY

Government publications are also available through booksellers

68p net

SBN 11 490793 5