REHABILITATION SERVICES

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There is a widespread belief that 'rehabilitation' is a good thing and that it ought to be systematically introduced into all health services. Before supporting the introduction or extension of rehabilitation services, however, it is well to take a critical look at this whole subject. It is particularly important to do this now because 'rehabilitation', like medicine, is being increasingly criticised by the very people who are most supposed to benefit from its practices - disabled people.

1. Chronic Problems in Rehabilitation

Rehabilitation literature, even from its earliest days, has been concerned with several questions which are raised over and over again, and despite the many answers they are still being asked.

Although there have been many attempts to define basic terms in the field, such as rehabilitation, disability, etc., no satisfactory agreement has been reached. In particular, why after so long, unlike other branches of medicine where general agreement about terms can usually be expected, is it still so difficult to be precise about what rehabilitation is meant to be and what it is meant to achieve?

Related to the difficulty in defining terms is the difficulty in identifying the appropriate, or basic, discipline that should support rehabilitation practice. Why has it proved to be so difficult for rehabilitation to become a recognised sector within the health service with its own accepted basic discipline behind it? There is confusion and disagreement about which discipline should be dominant in influencing the character of rehabilitation, or even if medicine is an appropriate base from which to develop a rehabilitation service.

Thirdly, how does the service offered in rehabilitation differ from those services offered in any good medical practice? It has been argued that the general goals of rehabilitation and all good medicine are the same - i.e. returning the patient to a maximum state of health, to a former job and to a normal way of life wherever possible. If this is so, then the main reason why the concept of rehabilitation was introduced into the health service was because the already existing medical practice was inadequate. Instead of improving the inadequate service, then, the response was to add yet another specialism to the medical service and to leave the inadequate service untouched.

Fourthly, how can the rehabilitation team work more effectively and harmoniously? This question, of course, also covers more sensitive questions about who should chair or co-ordinate the team? Which profession should have the final say in any decisions about an individual's rehabilitation programme and who should have the final legal responsibility for the patient? How can the rivalry between different professional workers, about who does what to the patient, be sorted out?

Since the idea of rehabilitation was first introduced the term has been applied to specialised practices in two quite separate services - medical services and vocational, or employment, services (and some might argue that a new, community or social rehabilitation service is also developing). The question is, what is the difference between medical and vocational rehabilitation and what unites these services under the same name?

Finally, it is being increasingly recognised that the 'normative' goal of rehabilitation (i.e. its aim of trying to make the patient look and behave as normal as possible) can mislead both the professional

and the patient about what problem really needs to be solved. It could be argued, for example, that the central problem should be seen as one of trying to make society fit for disabled people rather than trying to fit disabled people into society. Why are the goals set by the rehabilitation professionals not always appropriate when seen through the eyes of disabled people?

The fact that after so many years these questions still trouble the champions of rehabilitation strongly suggests chronic problems in the original concept. This view is supported by criticisms of the rehabilitation services that are coming from the new organisations of disabled people. In general these organisations criticise the rehabilitation services for failing to lead to any substantial improvements in the social situation of disabled people despite the earlier hopes when it was first being introduced into the health services. The relative gap between the situation of able-bodied people and disabled people has remained! Disillusion has followed and increasingly led disabled people to the view that they must become directly involved in setting up, staffing and running their own services. The crisis in rehabilitation is deepening.

2. Rehabilitation: Adjusting the Limits of Medical Science?

Medicine is basically concerned with curing illness and injury and helping the patient to be as normal as possible. Because of its 'normative' assumptions and its focus on the individual, the permanently impaired person continues to be seen as a patient, with a problem, and the search for a cure carries on. When no medicine is found to solve the problem other branches of the profession such as surgery and bio-engineering develop - e.g. retinal surgery to cure blindness, the attachment of artificial joints and limbs to cure motor impairments and the introduction of various transplants to replace tissues and organs.

When, however, the profession has done all it can and a permanent impairment still remains, medicine has little to offer. Faced with this reality, and the pressures of the second world war which demanded something for returning injured soldiers, the medical profession began to look at ways of helping impaired individuals fit into society. This did not mean that the profession began to develop a methodology appropriate to the social problems faced by disabled people. On the contrary, the profession applied its individualistic and 'normative' assumptions (i.e. to fit disabled people into the able-bodied and non-accessible society that was excluding them), and developed a new medicalised approach to social issues - rehabilitation. Thus a social challenge was reinterpreted as a problem falling under the control of, hopefully, the new branch of rehabilitation medicine.

The introduction of rehabilitation broadened the perspective of medical practice with disabled people and community goals were more forcefully encouraged. This, of course, underlines the fact that until then the medical profession had treated disabled people, like most of its patients, largely in isolation of social issues. It is worth noting that had such a social perspective been included in normal medical practice, as it should, then the emergence of a rehabilitation service would have been unlikely! Where medicine is socialised, properly incorporated into a comprehensive health service, and responsive to personal needs and community issues, then it is difficult to imagine a need for a specialised rehabilitation service for disabled people.

Introducing rehabilitation services into an inadequate medical service, however, had a positive effect on the lives of disabled people, at least when it was initially developed. Firstly, at the personal level, a more systematic approach to helping people with injuries and permanent impairments was introduced. This helped disabled people acquire some skills which could be of benefit to them when facing the barriers of an able-bodied designed social and physical environment. There was also the more systematic development of aids and appliances and the growing awareness of the need to adapt

patients' homes if disabled people were to move out of the rehabilitation centres. In time these developments meant that more disabled people could function independently in the community and acquire the social and personal experience which enabled them to make a more informed criticism of the health and rehabilitation services. Secondly, at the more social level, it brought the medical profession, and disabled people, into greater contact with an increasing number of different professions and some such professionals, like those in the employment services, had a quite different approach, which in turn helped disabled people better appreciate their situation as a whole. It became increasingly clear that the fundamental problem to be faced by disabled people is the socio-political one - that of struggling to make society fit for all the people who live in it.

The introduction of rehabilitation treatment procedures into the hospital, or special day care centre, was historically important because it influenced people to see permanent impairment as raising social, and not just personal, problems. The need for multi-disciplinary teams demanded a more holistic approach towards the personal and social problems faced by disabled people. Having recognised that the help given to people with permanent impairments was limited by its lack of a social and holistic perspective, a section of the medical profession organised for this gap to be filled. However, instead of pressing for a genuine socialised form of medical practice where the patient and the community are more involved in health issues they attempted the impossible. Under the term 'rehabilitation' they made a medical interpretation of the social problems facing disabled people and then tried to make this the dominant framework for the interventions of a whole team of multi-disciplinary workers. Despite good intentions, the attempt of the medical profession to make social judgements about fitting disabled people into an able-bodied world and to systematise this under the umbrella term 'rehabilitation' cannot succeed. Rehabilitation medicine is not the appropriate starting point for assisting disabled people to live in the community. Nor is medicine the appropriate base from which to develop a fuller understanding of the real disability felt by people who have a permanent physical impairment.

3. Who Decides What it Means to be Rehabilitated?

Starting from a medical base, with its focus on the individual and its aim of curing problems, rehabilitation moved into the arena of social problems. In doing this it tried to encourage a curative approach to the social problems that disabled people face. When it was possible to fit a disabled person into the able-bodied world then that person was considered to have been rehabilitated. This means, of course, that the person also had to accept a serious limit to what he or she expected to be able to do in the community - e.g. not use public transport, not be considered as a possible marriage partner or wage earner, etc. Rehabilitation professionals, therefore, are also always concerned about helping their patients adjust to their so-called limitations. This is important psychologically because it helps to brainwash disabled people into accepting that the present able-bodied world is the only world that one can fit into.

From this point of view the whole struggle to eliminate the social problems created by an able-bodied designed world, that disabled people are supposed to fit into, is best tackled by the experts who have the right rehabilitation approach - the able-bodied professional with a curative mentality (or even the disabled person if he or she has an able-bodied, or 'normal', and properly adjusted, mentality!) This, of course, means that disabled people are left permanently passive, permanently dependent upon 'expert' others to solve their problems for them and permanently within a limiting able-bodied social and physical environment.

To be a functioning human being within a social world, however, a person must play an active role in influencing the life of the community. For there to be any real advance in the integration of disabled people into society, therefore, it is necessary for disabled people to assert their own interpretation of what the world should be like, in their own interests, and for them to take an active part in actually helping to mould the world according to this viewpoint. This means that disabled people, like any other group who have faced social discrimination, have to organise to have a voice of their own so that their interpretation of the world can be expressed. Such organisations then become the channel for influencing the power structure of society and for communicating with other social groups. It is in this way that disabled people become the active agents of their own rehabilitation into the community. Their organisations become the court of appeal, deciding what is meant by rehabilitation, and the final judge of when disabled people have truly been rehabilitated into the community.

4. Rehabilitation, or Integrated Living Services?

When good medical practice is achieved with the active participation of patients and the community then there can be real progress in the elimination of permanent impairment both by prevention (e.g. reducing industrial accidents) and by more effectively utilising social wealth (e.g. spending money on health and related research rather than armaments) to develop surgical interventions, bio-engineering (e.g. regeneration of tissue, organs and limbs), tissue and organ transplants and improved artificial body parts.

The problem of dealing with the social barriers, however, requires the direct involvement of disabled people. With the active support of local communities the representative organisations of disabled people could be encouraged to set up ‘Centres for Integrated Living’. Such centres, run and largely staffed by disabled people, but working closely with health and social welfare professions and representatives of other groups in the community, could concentrate on teaching newly disabled people independence skills, providing information, supervising housing and public building adaptations, ensuring accessible public transport, monitoring the way disability is presented to the public and in schools, and ensuring full employment of disabled people. Integrated Living Centres could become the channel for ensuring that the voice of disabled people is accepted into all the decision-making processes of society. It is in these centres, in particular, that medical and other professionals could become a resource to be used by disabled people. Under these conditions the ‘expert’ or professional becomes a teacher rather than a therapist or someone who does things to and for disabled people. With the advent of good medical practice and the active involvement of disabled people in social affairs in their own interest the whole need for a rehabilitation medicine then falls away.