EDITORIALS

Rehabilitation: an integral part of clinical practice

At the introduction of the National Health Service, Beveridge saw rehabilitation as integral to the clinical process [1]. Over time it has come to be viewed as a ‘bolt on’ after health professionals have utilized the usual clinical options. Such an approach is increasingly regarded as outdated [2]. It is widely taught that rehabilitation should start at the beginning of a clinical episode. Indeed, rehabilitation may be found in the Accident and Emergency Department [3].

So exactly what is rehabilitation and how may it give added value to occupational physicians? Rehabilitation is a way of thinking, a philosophy within medical practice that states that there are always ways to help our patients even when traditional medical and surgical approaches are exhausted. Thus, physical, environmental and psychosocial considerations may all offer avenues to assist patients to lead the fullest life possible in spite of a medically incurable state [4]. This philosophy can be applied to many groups of patients who may have differing needs so that specialist areas of practice have come into being, e.g. neurological, musculoskeletal or prosthetic rehabilitation. Rehabilitation also relates to the interaction between the person with a disability and the health professionals who seek to diminish the impact of disability on the person’s lifestyle.

The International Classification of Functioning framework [5] describes a disease and its consequences in a systematic way, with impairment being the anatomical or physiological consequence of the disease, function (or lack thereof) being the consequence and participation being the end result at the level of the individual’s function in society. We recognize that there are intrinsic and extrinsic factors which, while not impinging on the disease per se, influence the effect that disease has on the function of the person, whether at task level or at the level of the person’s participation in society.

This view of the impact of disease on the person can be applied either in the context of generic services (e.g. primary care) or at the level of specialist rehabilitation provision. It can be used during a clinical consultation, or by using a rehabilitation team to overcome the effects of impairment. Consider a stroke which develops during an operation; providing rehabilitation at a level the post-operative patient can tolerate gives hope of functioning again and is a powerful help to patient and surgical team alike. The specialist neuro-rehabilitation team complements the surgical team to produce results that appear to be more than the sum of the parts.

Rehabilitation teams view the rehabilitation process as ‘enabling’, centred on the person, but being ‘time-limited, planned with well-defined goals and means. Several players work together to give the necessary assistance to the user’s own efforts to achieve the best possible ability to function and cope, independence and participation socially’ [6].

Thus, rehabilitation can be viewed both as the purveyor of specialist services and as an enabling process. The primary practitioners within the rehabilitation team are the rehabilitation physician, the various therapists, often a psychologist and sometimes others (e.g. a dietician) with the individual at the centre of the process. This person is rarely isolated but exists within a family and often a workplace and indeed these interactions occupy much more of the person’s time and life than the interaction with the rehabilitation or other clinical team. Rehabilitation will not be effective if it is available in secondary care alone but also needs to be followed by specialized community rehabilitation. Such teams in primary and secondary care ensure that patients maintain, or regain, their activities, e.g. mobility.

A visit to the patient’s home can bring dividends, as can a visit to the workplace. These are the places where the person spends most of his/her time and has most of his/her interactions. Thus, a home visit by an occupational health or rehabilitation professional (where the person is in control of his/her situation and the professional is the guest) may reveal family or psychological factors (both positive and negative), which were unsuspected but which may be key to resolution of problems; issues unlikely to unravel in a standard clinical interview. Physical barriers to (re)integration into the community can be seen and the potential role of assistive technology (such as powered electric wheelchairs) can be assessed. Finally, issues relating to access or transport become clearer and frank and open discussions may take place more easily in the home [7].

Using the understanding of rehabilitation in the context of a philosophy, or the biopsychosocial or the International Classification of Functioning, Disability and Health (ICF) model [5] (see Figure 1) we see that the person who, say, presents with back pain and is off work, may be experiencing not only impairments such as pain and limitation of movement but also that return to work (RTW) may be hindered by intrinsic factors such as a belief that it will cause the condition to recur. There may be family issues, such as the minding of children or frail elderly relatives. There may be external barriers (e.g. access) or a poor relationship with the line manager [8]. Employers may not understand the disease,
believing that the employee must be 100% fit prior to RTW and health professionals may not understand the urgency of returning to the workplace, treating at a speed or intensity which is insufficient to preserve the job [9]. In too many cases even when the individual therapist understands the urgency, the system does not allow her/him to respond more appropriately. Furthermore, the complex distinction between disease and disability is often not understood. Thus, many with chronic illness do not consider themselves to be ‘disabled’ and most people with disabilities do not see themselves as ‘ill’.

Many conditions result in a static disability that may need little ongoing support from health professionals. Some, however, go through a period of sustained but diminishing improvement, e.g. following a stroke. Here, it is important that the person has access to early intensive multidisciplinary (usually inpatient) rehabilitation to maximize the plastic capacity of the brain which is greatest early after insult.

Other conditions may progressively deteriorate, e.g. motorneurone disease. The aim of rehabilitation then is to decrease the rate of decline of function and it will often be provided in the community, adjusting rapidly to changes in the condition. Other diseases may be associated with a fluctuant disability which is difficult to accommodate and predict, e.g. rheumatoid arthritis. They may create major difficulties for individuals and families in creating RTW plans, an essential ingredient in minimizing sickness absence by creating a clear pathway back into employment [10].

The concept of a period of ‘disability leave’ can be useful in the presence of such conditions [11]. It is also valuable when the person has had a major insult such as acquired brain or spinal cord injuries—or a disease which has to be brought under control, say by powerful modern drugs. The ability of the employer to adjust the job, the workplace or the tasks is crucial and needs to dovetail with the rehabilitation which is occurring. This implies that the overseeing occupational physician knows something of this process, its potential and its limitations.

Since mental health impairments are a great cause of loss of work and of receipt of incapacity benefits [12], the same processes are used to diminish their impact. The ICF or the biopsychosocial model will be needed to frame the rehabilitation and treatment processes. Indeed, the British Society of Rehabilitation Medicine stated ‘emotional agendas need resolution before physical goals can be achieved’ [2]. This creates major challenges to employers to sustain those with mental health difficulties when they RTW: we have to remember that some of the most creative of people have had depression or even bipolar disease.

If rehabilitation is primarily a way of viewing medical events and placing them in the context of the whole person it is important to the occupational physician that the techniques and skills of rehabilitation are available to them as a practice to be called on, with rehabilitation physicians and occupational physicians understanding what the other does, being able to access each others’ services easily, and perhaps being exposed to overlapping training or joint CPD. We should be fighting together to achieve advances in undergraduate and postgraduate education and work together on policy matters.

In a country where infectious and childhood diseases have long been conquered, where many survive cancer, and where the expectation of life of a female child born today is >80 years, medical practice must reflect these facts and employment must also live with them. This is not a failure but a sign of our success. It is only a sign of failure when we do not equip our practice to maximize the person’s ability and we continue to believe that medical practice is only about cure. Then, we do not acquire the knowledge or resources to address our potential success and turn it in to reality for our patients. We need to use rehabilitation, or at least its philosophical approach, early—not as a bolt on.

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Conflicts of interest
A.O.F. is Chair of the Clinical Advisory Board of Kynixa—a vocational rehabilitation company.

References


