CHRONICLE

Notes on a World Congress

REHABILITATION OF THE DISABLED

The International Society for the Rehabilitation of the Handicapped held its 9th World Congress in Copenhagen in June 1963. Some 1700 people from 66 countries took part including representatives from the Danish Red Cross. The next Congress will take place in Munich in 1966.

Several articles have been published in the International Review *relating to the rehabilitation of the disabled, many National Societies being concerned with this problem in their respective countries. Mr. Droin, the author of several articles which we have published on this same subject,*[1] *attended this important meeting, and gives us below details of the themes dealt with by the Congress and an account of the ideas discussed.* (Ed.)

Although the problems affecting the disabled were discussed from all angles, the speeches and discussions were on the whole concentrated on the two themes of the Congress : *prevention* and *rehabilitation*. By the former is meant not only prophylactic measures against crippling diseases and precautions against accidents, but also the prevention of disablement and indirect consequences of any traumatic condition as soon as it is observed.

Rehabilitation involves the faculty of working out satisfactory solutions even for the most serious cases as well as concern that the patient, never left to fall into an attitude of passivity, is instilled with confidence from the outset. This is not only a medical, surgical, educational, economic, technical and vocational problem, it is also a social problem which is of concern to the whole community. Active participation by everybody is on the way to being put into practice

[1] See notably *Revue internationale*, March 1961.

in most of our countries. However, the President emphasized the need for co-operation among official and private organizations. Rehabilitation specialists will not be able to cope with their tasks without the assistance of non-specialized and voluntary workers. Rehabilitation is the *right* of the handicapped and the *duty* of the community.

This was to be the predominant idea throughout the Congress for this is one of the invariable factors in any action undertaken for the benefit of the disabled.

1) **Prevention.**—Year by year the concept of a cripple or a disabled person becomes wider and the rehabilitation programmes progressively develop and go deeper into the problem. On the one hand, certain illnesses which formerly were sooner or later fatal can be cured today, but nevertheless leave the patient handicapped (for example : leprosy, eye diseases in hot countries). On the other hand, accidents are increasing to a greater extent, at work, in sports and on the roads. Each of these three categories of accidents is the subject of study and research as well as special preventive measures.

Industrial accidents are perhaps easiest to prevent. The systematic analysis of accident causes is constantly bringing about improvements in working conditions, in plant layout, equipment, tools and safety precautions. As the human element plays a large rôle, professional training of workers is called for in the first place in order for them to assimilate the automatic processes and acquire the indispensable reflexes ; machinery must be adapted to suit the operatives at the same time as workers must be adapted to the machines. Proof of this is given by the high proportion of accidents involving the do-it-yourself amateurs, insufficiently trained and working with unsuitable tools, who fall into the error of carrying out processes for which they are unqualified and taking initiatives of which they are unable to assess the danger.

A thorough study of accidents in the field of sport leads to a reconsideration of the instructions given to athletes and players in order to ensure that they take certain precautions which are consistent with the rules of their game ; this, it will be understood, is a psychologically delicate problem since the impulse behind the athlete urges him to take risks, specially in competitive sport.

The modern highway is a " battlefield " which causes more deaths and injuries than the most devastating wars in history. The comparison of injured on the road with military wounded is not limited merely to the numerical aspect. Like victims of armed conflicts, those on the highway come from the most active sections of the population ; just as in war, injury is brutal, affecting individuals who are sound physically and mentally and therefore particularly suited for rehabilitation. The same conditions making for successful rehabilitation are therefore to be found among road accident victims as among the wounded of the Second World War, who provided a source of decisive experience from which was evolved in a few years the science and technique of rehabilitation.

Particularly worth mentioning is the work in this field by the international organizations, such as that of the International Labour Office regarding social legislation affecting work and social insurance ; the United Nations and the World Health Organization as regards technical assistance and public information. With respect to road accidents, no less a matter is involved than the awakening of world opinion and the rousing to unremitting action against this scourge of modern times. Let us also not omit the work of certain National Societies of the Red Cross, especially the French Red Cross with its first-aid organization and the Italian Red Cross with its ambulances and first-aid posts on the main highways.

In all trades and professions, disablement and chronic ill-health, giving rise to absenteeism, are not caused solely by accidents or industrial illnesses (such as various forms of toxic poisoning). The cause may well be the harmful and cumulative physical or mental effects due to detrimental movements or position of the body, to an unhealthy atmosphere and to psychological and social errors at any level in the hierarchy of the enterprise or administration. These problems are being investigated thoroughly. They are important in sickness and accident insurance. As soon as trouble is spotted, even in a mild form, efforts are made to eliminate the cause and, if need be, to modify working arrangements or induce the patient to undergo a course of functional training. Special attention must be paid, for example, to even slight disablement due to spinal defects, among both manual and sedentary workers. There are also certain

ailments and abnormal fatigue which sometimes affect domestic workers and housewives, due often to lack of adjustment, housework rarely being the subject of systematic training.

Examination into the origin of accidents, whether on the road or at work, and even when they occur with sudden violence, reveal them to be the culmination of a chain of events which was not noticed early enough. Analysis often reveals an accident to be the consequence of a series of negligent acts or omissions, often of no importance in themselves but of which the result or the cumulative effect has caused the accident. It is for this reason that statistics lay the blame more frequently than is generally thought on the human element, which apparently plays the major rôle in road accidents. It has been said that 90% of the cause is the human element, as against 10% for technical factors.

2) **Rehabilitation**.—The general principles of rehabilitation (medical, occupational therapy, social and industrial) and the rules governing the continuous process of rehabilitation are well known. There is therefore no need to dwell on them here, except to stress a few points which were particularly emphasized at Copenhagen.

One of these was the importance of initial diagnosis and prognosis. Present-day methods of physiological, psychological and psychotechnical investigation enable rapid and sufficiently accurate *evaluation* of remaining capacities, latent possibilities which can be developed, and the subsequent deterioration to be prevented. Once the situation is assessed the rehabilitation programme can be drawn up and instituted without delay, its approximate duration calculated and its ultimate objective determined. This implies defining at what stage of social and professional reintegration the patient may complete his rehabilitation treatment either by normal work in a factory or office (after following courses in a technical school with fellow students who are in good health or at an industrial rehabilitation centre for the disabled) or by employment in a " sheltered " workshop or as an inmate of a home equipped with a workshop, or by work at home. In the last resort, when there is no possibility of undertaking, even partially, a productive occupation, the patient may be accommodated in a place where daily leisure is planned in a manner suitable for the patients' tastes and abilities.

The methods used to make this evaluation vary from country to country. Several remarkable expositions, too technical to be reproduced here, explained the high degree of accuracy attained nowadays by a combination of psychotechnical tests and short-term trials at the work bench based on principles of continuous orientation procedure. In this respect, mention may be made, in particular, of the Tower system in use in the U.S.A. and which covers a wide range of simulated job functions.

The final objective should, on the one hand, aim at maintaining at as high a level as possible the patient's morale by positive motivation, but at the same time should not be based on too optimistic a forecast. Indeed, to prepare a disabled patient for a normal job in a factory or office and subsequently to realize that the degree of disability makes it after all necessary for the patient to be employed in an occupational workshop for the disabled, is more harmful than the converse error. In the first of these two eventualities, both the disabled person and the employer would be disappointed, whereas in the second hypothesis favourable results attained in the workshop would facilitate the patient's accession to normal employment.

For this reason the establishment of a large number of occupational workshops for the disabled, or " sheltered " workshops for observation or " selection " of certain marginal cases is being advocated more and more frequently. To interest industrialists in the organization of such workshops would be useful not only with a view to obtaining their orders, but also to giving them the assurance that efforts would not be made to foist onto their business, persons whose disablement prevented them from coping with the demands and output schedule of the factory or office.

In " sheltered " workshops, which may *a priori* be expected to show a deficit, the psychological, social and economic difficulty lies in the fact that remuneration earned by the disabled worker must not be based on output, but on the needs both of the patient and of his family. A different solution is applied to this problem from one country to another depending on the social insurance systems in force.

The compromise solution, consisting of an enterprise reserved solely for disabled workers which aims at paying normal wages and

at being self-supporting, more often than not gives disappointing results, both economically and psycho-socially.

Success in occupational rehabilitation is necessarily affected by the patient's age when the injury occurs, by his or her degree of intelligence, mental stability and the attitude prevailing in social and family environment.

The most difficult cases are those in which the physical disablement or handicap is complicated by effects on the mentality or character. It is obvious that in readjustment, intellectual development, mental behaviour and adaptability are preponderant factors, whatever the degree of physical injury.

3) **The Aging Factor.**—This has only recently been receiving study by specialists. It sometimes happens that a disabled or chronically sick person, whether from childhood or from maturity, after successful rehabilitation and integration, and after many years of a normal career, becomes prematurely old as a result of the physiological toll of the disability. For example, vascular disorders suffered by patients having had amputations ; deformation of bones in paralysis cases, giving rise to motory difficulties and general fatigue ; visceral complications in paraplegic patients ; and in other cases a progressive decline of physical and mental substitute abilities. Regular medical check up, coupled where necessary with occupational therapy may sometimes postpone these complications, but in many cases retirement from work before the normal age is essential and consequently this requires reconsideration of social insurance benefits.

4) **Technical Progress.**—Rehabilitation techniques have today attained an amazing stage of development : with recovery surgery, appliances for functional training, fittings for amputation or paralysis cases, tools and mechanical or electronic devices for rheumatic cases, for the deaf and the blind, we are witnesses to an era in which art and craftsmanship substitute for nature in offsetting man's physical shortcomings.

An exhibition of aid appliances, organized as an item in the programme of the Congress, displayed the most amazing achieve-

ments of inventors and research workers : a typewriter worked by breathing, each variation in the force or length of expiration corresponding to a particular sign or character ; electrically powered armchairs equipped with caterpillar tractors to climb stairs ; motor cars with special gadgets ; and the most moving of all, artificial upper limb attachments in metal or plastic intended for use by phocomelia children, the victims of thalidomide, who are fitted already at eighteen months of age in order to enable the mental adjustment to take place as early as possible, together with the development of muscles in the shoulders, thorax and back in the exercise of the use of these delicate appliances, each control lever of which is connected to a minute amplifier.

5) **Housing**.—Various countries are concerned with the provision of accommodation especially designed to simplify the daily life of the disabled. Whilst this requires special architectural arrangements (such as elimination of threshold and entrance steps, flats on ground floor level, lifts wide enough for wheelchairs, special kitchen and sanitary fittings), the building of blocks of flats exclusively for the disabled is to be avoided. It is preferable, from a social standpoint, that buildings should have no more than a fraction of such specially designed accommodation, for any concentration of invalids should be avoided. Indeed, what would be the use of efforts to reintegrate the disabled into normal life if they are gathered together in a housing scheme, thereby creating a settlement apart for them. Sociologists and architects concerned nowadays with large housing estates and new towns advise against any form of segregation according to age, social strata, profession, etc. This is equally valid for the disabled who should not be condemned to live on the fringes of society. For want of a better solution, this has still no doubt to be adopted for the greatly disabled without any family and in need of regular nursing care, but if possible only in homes having a few patients.

However, even for this category, there is an exemplary design of a block of buildings, of recent construction, in the Copenhagen orthopaedic hospital complex. A large proportion of these buildings house " normal " families without any invalid member, some families with one disabled member and there are also specially

fitted flats for couples or single disabled persons. The living quarters are directly connected by a lift to the underground garage where the disabled park their cars. If any of these disabled persons requires help or special care, the hospital staff are available, and indeed by a corridor they have direct access to the hospital in order to go for regular treatment or to the workshop. This is a fine example of de-segregation.

6) **Team Work and Case Work.**—For the last 20 years the main pioneers in rehabilitation have been insistent on close team work. Surgeon, doctor, therapist, psychotechnician, educator, trainer, employment officer, social worker, should not each have an independent approach one after the other ; their action should be concerted. The validity of this principle is proving to be more and more undeniable ; and yet in many countries team work has not been instituted. The reason is often the lack of qualified personnel or an inability on the part of these specialists to get together.

And even when a team is a well organized and experienced unit, inexplicable failures occur, nevertheless. Study of such failures shows that although the team work principle is a fundamental necessity, there comes a time when the disabled person who is well on the way to rehabilitation should become not only an active, but even the main, member of the team and begin step by step to dispense with the team's help. This is the only way for the patient to resume his or her personal responsibilities. To attain this objective, it is important that at some intermediate stage between dependence and self-reliance, the social worker (trained in case work) takes up his place in the team and by association with his individual case induces him or her to make decisions and helps the person to recover that self-reliance which is the very keystone of rehabilitation.

The transition from concerted team work to a joint effort by two co-workers might appear to be a delicate phase, but as it is in the nature of things, it takes place without difficulty.

There is no conflict between team work and case work, but the former must progressively be replaced by the latter. It is then that it becomes obvious that the training and functions of social workers prepares them to make closer contact with the patient as an individual, whereas the other team members, whilst naturally

concerned with the patient, tend rather to treat the case in point in the general run of the mill.

7) **The Disabled Person's Vocation.**—The only truly disabled person is the one who has still to become adjusted to overcome his infirmity and to look upon it as an impetus. For his intimates and helpers, it is an honour to contribute to the success of the painful and laborious transmutation of a handicap into an asset.

The disabled person is equal to a person sound in body only when, thanks to the help he has received, he is reconciled to his disablement and enters with a will into a new career ; not one imposed upon him, but a vocation freely chosen taking into account the new facts to be faced as a result of his disablement.

But a vocation once acquired needs constant mental stimulus and adaptation to circumstances. Like everyone else, the disabled have their ups and downs. As the believer must each day meditate and sustain his faith, so must the disabled each day accept his lot and persevere in his vocation. This is what enables him to feel in his element in a world of healthy people where he is accepted without reserve.

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