REHABILITATION: CONCEPT AND PRACTICE*

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The word "Rehabilitation" has been used in many contexts and in many different ways. In the medical field its interpretation has changed considerably in the period from the years before the first world war to that after the second and the ensuing extensive social legislation which followed the Beveridge Report. Changes in definition, although usually enlarging the scope, do not necessarily mean increased application. The multiplicity of statutory and other agencies which have a part in the method and means of returning patients to full industrial and social contact has contributed to the failure to progress with the changes in definition.

Any review of rehabilitation services in this country shows many gaps which are due primarily to a failure by the medical profession as a whole to accept the dynamic philosophy of treatment demanded by rational schemes of rehabilitation and secondarily to the failure of effective co-ordination and integration between government departments, hospitals, general practitioners, public health services, and industry.

The prevailing tendency to isolate rehabilitation in the sphere of physical medicine is criticized as an attempt to evade a responsibility which the whole practising profession must accept. The fundamental function of industry in the process and the importance of the role of the Industrial Medical Officer are emphasized. Resettlement in employment is the crux of the whole process of rehabilitation.

In choosing the title, I wondered whether to concentrate on a purely academic approach or whether to detail my experience in a particular branch of medicine relating mainly to industry. In the end I have compromised by a combination of both. First an interest in occupational health, which began as a student, was stimulated when I was thrust into the vortex of the daily casualties of a Welsh mining community. Rehabilitation was a word used in limited circles, mostly outside medicine, and understood by few, but a youthful anxiety to try to get men back to work earlier than they did in those days of 1924 was the glimmering in my own mind of our modern approach. This was no pioneer work; it had already been undertaken by Robert Jones, Agnes Hunt, Moore at Crewe, and others, but it was an instinctive reaction to the months of suffering and waiting which was the lot of many patients; waiting until the wounds healed; waiting until the claim for compensation so bitterly fought, was settled; waiting

to be allowed to recover their sense of independence; waiting to be allowed to face death daily at their work. It was not the hacking coughs and the marked dyspnoea of so many which was disturbing, as much as the poor results of the traumatic surgery of the era which constituted a major challenge.

Immobilization for months in splints and later in plaster, more months spent hobbling about aimlessly trying to restore function in limbs too long rested and wasted, months spent wrangling in the Courts about differing and sometimes conflicting opinions of medical experts: months which embittered men and their families, and much of the blame could properly be stated to be the responsibility of a profession much too slow, or, to be charitable, too conservative to learn the lessons so clearly demonstrated to it by those pioneers in Britain before, during, and after the first world war.

It has been said that rehabilitation is physical medicine: how shockingly insular. I am not a physical medicine expert. Nevertheless, I have occupied a somewhat privileged position to survey the scene and watch the developments. In 1940, I became Industrial Medical Officer at a Government

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Training Centre of the Ministry of Labour and National Service, training all types of people for work in the war effort, girls, women, boys, men, able-bodied and handicapped; all who could walk and breathe were potential trainees. The adaptation of down-and-outs, social outcasts, and quite severely disabled persons to economic working units was a tremendous achievement, spurred on by the urgency of the manpower need of the war, but it provided a real insight into the problem, an insight into the potential of disabled or handicapped people who had been regarded as cripples with no future. This work continued during the war years, and when peace came, was adapted to the training of ex-servicemen for peace-time needs, for men and women who had lost their opportunities through their period of war service.

History of Legislation concerning Rehabilitation

In 1941 the interim scheme of the Ministry of Labour and National Service in relation to disabled persons linked hospitals and the employment exchanges together for the first time. The Tomlinson Report was published in 1943 and greatly stimulated medical and lay interest in the problem. It envisaged a post-war scheme to deal with the casualties of war and peace, and encouraged action on the part of several government departments concerned.

In 1948 I was appointed a Regional Medical Adviser to the Ministry of Labour and National Service with the following duties:

- (1) to act as Regional Medical Adviser to the Regional Controller on general medical problems arising out of resettlement work in respect of disabled persons;
- (2) to make inquiries and advise, as found necessary, on special problems of that kind;
- (3) to advise the Regional Controller on organization and content of medical services in vocational training and at industrial rehabilitation centres;
- (4) to assist in developing the fullest co-operation within the Region between the employment service of the Ministry of Labour and the hospital and other medical services and the medical profession generally, in relation to the problem of placing disabled persons;
- (5) by association with appropriate departments of universities or approved hospitals, or in other ways, to maintain a research and teaching interest in medical aspects of the placing and resettlement of disabled persons.

This appointment was made by the Ministry of Health, the holder being seconded to the Ministry of Labour. The work involved a close relationship with Regional Hospital Boards and teaching hospitals, contacts with hospital staffs in two Regions, with the local authorities of the area, and liaison with general practitioners. The University relationship had already been established by my appointment to a part-time lectureship in occupational health.

An objective view could be taken from this particular position of the attitude of medical teachers to the problems of rehabilitation, of the differing approach by two Regional Hospital Boards and the teaching hospitals together with the general reaction of the medical profession to the new demands made upon it.

Twelve years have passed and there have been many changes, but Departments work all too slowly, and at times our own profession has moved even more slowly.

The Impact of Post-war Legislation

Public reactions to the social problems of the crippled, the disabled, and the handicapped have not inherently changed, in spite of a great deal of lip-service to the concept of social welfare or to the achievement of social independence, which should be the ultimate aim. Conservatism, which can be an admirable excuse for the non-progressive in our profession, has severely limited both the potential and the ultimate successes. When distinguished members of our profession say that consultants have nothing to learn about problems of rehabilitation, that it is largely a matter of education of the general practitioner—and this is uttered in a mainly lay Departmental Committee—when other people say that the term "Rehabilitation" should be put into cold storage for 20 years, it seems doubtful whether there is any real hope that our profession will accept its social responsibility.

The concept is best approached on a chronological basis. First there is the Report of the British Medical Association Committee on Fractures which stimulated the appointment of the Delevigne Committee on the treatment of fractures, which reported in 1936-37. The B.M.A. definition of 1934 was:

"The word 'Rehabilitation' may be taken as applicable to a stage between the completion of a course of massage and exercises in the Massage Department and the point where the stresses and strains of heavy work can be undertaken. It is an active stage, directed to a complete restoration of function."

The Delevigne Committee Report resulted in the setting up of fracture clinics throughout the country, which later developed into the Emergency Medical Service, set up in 1938-39 to deal with the expected casualties of an approaching war. Under the stimulus of the imperative war-time demands for manpower, public interest was aroused by the need for the utilization of disabled or handicapped persons in the national effort, and many people realized for the first time that sub-standard individuals could contribute a full day's work if they were appropriately handled and allocated.

In 1941, Ernest Bevin, then Minister of Labour and National Service, appointed a Departmental Committee on the Rehabilitation of Disabled Persons, under the Chairmanship of George Tomlinson, who was Parliamentary Secretary to the Ministry. Their remit was:

(a) to make proposals for introduction, at the earliest possible date, of a scheme of rehabilitation and training for the employment of disabled persons not provided for by the interim scheme introduced by the Ministry of Labour and National Service in October 1941;

(b) to consider and make recommendations for the introduction, as soon as possible after the war, of a comprehensive scheme for—

- (i) the rehabilitation and training of
- (ii) securing satisfactory employment for

{ disabled persons in all categories.

(c) to consider and make recommendations as to the manner in which the scheme proposed for after the war should be financed.

The Tomlinson Report has been one of the great social advances of our time; most of what has been done in this country in rehabilitation and resettlement is a direct result of its recommendations. The conclusions of the Tomlinson Report (1942) were as follows:

(1) Rehabilitation in its widest sense is a continuous process, partly in the medical sphere, partly in the social and industrial spheres. The medical side, in spite of the developments brought about under the Emergency Hospital Scheme, still falls short of what is required, and, so long as this continues to be so, the problem of rehabilitation at the post-hospital stage, is correspondingly more serious and extensive. In the meantime, concerted action is necessary to see that the existing hospital facilities are in use to the fullest extent and to the best advantage for those in need.

(2) Close co-operation in the Health and Industrial Services is necessary throughout the whole process. This is particularly important at the stage between the end of medical and the beginning of industrial rehabilitation; but it should be continued to the later stage of resettlement, so that the industrial services have the benefit of medical advice, and the medical services can acquire knowledge of the effect of disablement upon occupational capacity.

(3) On the industrial side, continuity of the service is essential. It should start in the hospital, it should continue throughout the post-hospital stages, it should not end with the first placing in employment, but should follow up until resettlement is completed. This calls for a specialist service within the Ministry of Labour and National Service.

(4) Ordinary employment is the object and is practicable for the majority of the disabled, with the goodwill and co-operation of the representative organizations of employers and workpeople, in conjunction with the

Health Services and the responsible Government Departments.

(5) A minority of the disabled require employment under sheltered conditions, and such employment should be provided through production for Government and other public services.

These conclusions led the Committee to their final recommendation which was for the establishment of machinery to augment the work of the Departments responsible for the many different aspects of the whole scheme. These Departments were: Ministry of Labour and National Service, Ministry of Health, The Board of Education, together with the Scottish Departments of Health and Education, Ministry of Pensions, The Home Office, and Ministry of Fuel and Power.

It was suggested that an inter-Departmental Committee should be appointed forthwith to ensure that adequate preparations were made for the introduction of the scheme immediately after the war. The recommendations of the Committee dealt with eligibility, medical rehabilitation, post-hospital rehabilitation, resettlement, employment under sheltered conditions, employment of the blind and the deaf, employment on own account, placing and follow-up work, survey of occupations, and finance.

The following extract from the Tomlinson Report is relevant to the concept:

“The successful rehabilitation of a person disabled by injury or sickness is not solely a medical problem. Rehabilitation in its strictly medical sense means a process of preventing or restoring the loss of muscle tone, restoring the full function of the limbs, and maintaining the patient's general health and strength. The process should begin as soon as possible after injury or operation, and, in the case of acute or prolonged illness, as soon as the patient's condition permits, and it should continue not only throughout the period of hospital treatment, but also during the subsequent stage of convalescence, whether that takes place in hospital, or is provided in a separate centre. Continuity of treatment is essential to achieve the aim of restoring a patient's mental and physical capacity at the earliest possible date, and to the fullest possible extent.”

In 1943 the Reports were published of the Scottish Experiments in Social Medicine at Gleneagles (later at Bridge of Earn) and that on the development of the Miners' Welfare Rehabilitation Centres.

In 1944 the Disabled Persons (Employment) Act was passed. It was the first positive step taken as a result of the Tomlinson Report, and much of the subsequent work of the Ministry of Labour and National Service flowed from it.

In 1946 a British Medical Association Committee reported on Rehabilitation and defined the problem as follows:

"Rehabilitation is the fullest possible restoration to normal life and working efficiency of a person incapacitated by disease or injury. This is primarily a medical problem, but one in which industry and the social services must play an essential part. Treatment must be directed not only to obtaining full physical and mental recovery, but also to restoring a patient's enjoyment of his former cultural and social activity and his resettlement in work best suited to his capacity."

In 1949 the Ministry of Health, in a circular sent to all Hospital Boards, Boards of Governors, and Hospital Management Committees, urged the medical profession to accept an additional social responsibility in relation to their patients. The circular stated that treatment should not end with the departure of a patient from hospital, or with the getting up out of bed after severe illness, but should be continued into the stage of resettlement in appropriate work. Further, that treatment was the responsibility of the hospitals and the medical profession, but that placing in work was quite clearly the responsibility of the Ministry of Labour and National Service through its placement and Disabled Resettlement Officer Services: an excellent concept, but its implementation has not been achieved. At the same time it was urged that all larger hospitals should appoint one or two senior members of the staff to supervise rehabilitation services within the hospital or hospital group. It is unfortunate that the medical profession found in this apparent contradiction between the acceptance of individual responsibility and the delegation of responsibility, an excuse for the lack of progress which should have been made. The result was that the profession accepted individual responsibility in theory, but was opposed to the appointment of colleagues with additional responsibility. That situation is largely maintained today.

In 1954, the B.M.A. second Committee on Rehabilitation, in giving evidence to the Piercy Committee, produced this definition:

"The rehabilitation of a patient is an indivisible process beginning with the onset of sickness or injury, and continuing throughout treatment until final resettlement in the most suitable work and living conditions is achieved. Its aim is to enable him to resume his place as a responsible citizen, and to contribute in the fullest possible manner to the physical, mental and social welfare of the community. The whole man must be rehabilitated, the patient being dealt with as an individual with a distinctive constitutional make-up, with his own emotional life and moral values and with a particular upbringing and social and economic background. In this sense, every aspect of medical care is a part of rehabilitation."

The Report goes on to say:

"It is this comprehensive conception of rehabilitation which places upon the medical profession special responsibility, for only a person who is medically trained can advise the patient with a full understanding of his disability. Similarly, the complete confidence of the patient will be gained only if he can feel that he is being guided by someone who understands all aspects of his problem. There must, therefore, be continuous medical supervision of the patient throughout the process of rehabilitation."

In 1955, the Report of the expert Committee on Medical Rehabilitation of the World Health Organization made a statement of general aims and principles, which were virtually in accord with the definitions of the British Medical Association, and finally there was the Report in 1956, of the United Nations Working Party on the Rehabilitation of the Physically Handicapped. The following is an extract from this Report:

"The time has long passed when a handicapped child or a disabled adult should be regarded as a subject for commercial exploitation, and trained for the occupation as a professional beggar, or even to be considered as a mere object of charity. Modern methods of medical and sociological science have opened a new horizon of promise for such individuals, but if this promise is to be fulfilled and the handicapped person is to have his full chance in life, there must first be a new evaluation of physical disability, based on the following six theses:

(1) That the handicapped person is an individual with full human responsibilities which he shares in common with the able-bodied, and that he or she is entitled to receive from his or her country every possible measure of protection, assistance and opportunity for rehabilitation.

(2) That, by the very nature of his physical handicap, he is exposed to the danger of emotional and psychological disturbance resulting from a deep sense of deprivation and frustration, and that he therefore has special claims on society for sympathy and constructive help.

(3) That he is capable of developing his residual resources to an unexpected degree, if given the right opportunity for so doing, and of becoming in most instances an economic asset to the country instead of being a burden on himself, his family and the State.

(4) That handicapped persons have a responsibility to the community to contribute their services to the economic welfare of the nation, in a way that becomes possible after rehabilitation and training.

(5) That the chief longing of the physically handicapped is to achieve independence within a normal community instead of spending the rest of his life in a segregated institution, or within an environment of disability.

(6) That rehabilitation of the physically handicapped can only be successfully accomplished by a combination of medical, educational, social and vocational services, working together as a team."

The changing attitudes expressed in these definitions indicate the developments that have taken place in the approach to rehabilitation. Nevertheless, unless some really positive action results from the dissemination of these formative ideas, definitions tend to remain mere skeletons. To appreciate all the agencies involved in the problem of the transfer of man from bed to work provides what is probably the real reason for a comparative failure of the service in this country. The word "comparative" is used lightly, because we are still ahead of many countries; we could have been ahead of all in practice as well as theory if a little more positive action had been taken.

The numerous bodies concerned with rehabilitation include the statutory authorities, the Ministries of Education, Health, Labour, Pensions and National Insurance, the National Assistance Board, the Hospital Boards of the National Health Service, the General Practitioner Service, the Public Health Service, and the Local Authority Health and Welfare Service. A host of voluntary bodies contribute their parts to the solution of the problem; also universities, industry, trade unions, employers' organizations and, last, but not least, industrial medical officers.

The Present Position

It is the lack of integration of all these services which has been the main delaying factor in the proper development of the scheme. If the problems of the different services are envisaged and particularly those of our own profession, it is realized first of all that there is an absence of modern thought in the teaching stage when the medical student is at his most impressionable age. The problems of the National Health Service have almost engulfed the medical profession, which consequently has failed to appreciate the vital contribution which a dynamic philosophy of treatment can achieve. It has shown a lack of vision or even a desire to eschew anything which appears new (apart from drugs) and an almost fanatical belief in the methods of the past. It may be that the increasing fragmentation of medicine, particularly of the specialties, may have played a part in this. The welter of post-war social legislation has almost submerged all except the cynical, the embittered, and the angry, but positive constructive thought or action rarely emerges from these groups.

In spite of the brilliant achievements of a few enlightened doctors who had the courage of their convictions, too little has been achieved in the sphere of rehabilitation. Platitudes, professional jealousies, empire building on the part of lesser known specialties, apathy, and plain ignorance are charges which have to be met. One expert has divided the medical

profession into five groups on their attitudes to rehabilitation: tolerant 30%, passive 50%, interested 15%, enthusiastic 3%, expert 2%.

The past 12 years have been spent trying to educate, to encourage, to cajole, even to force, colleagues to appreciate that medicine now includes social responsibilities towards patients. These responsibilities must be accepted as a fundamental part of the modern concept of treatment in that the work is not completed until the patient is back at work, properly settled in appropriate employment. This new concept of treatment also demands that doctors are part of a team which involves many other agencies. Doctors are essentially individualists, but occupational health shows that success can be achieved only as members of a team; this is equally true in the concept of rehabilitation.

There is one bright light on the horizon, and that is the avidity with which final year medical students accept the philosophy of rehabilitation and ask for more in the few lectures which are allowed in the curriculum. The tragedy is that rehabilitation should not be taught as a specialist subject, but as an inherent part of all clinical teaching; that will be too much to expect of this decade. Nevertheless, junior resident medical staff are more ready to accept this wider concept than their seniors, and one Regional Hospital Board at least, has instituted courses in rehabilitation for junior resident hospital medical officers during their first two years. This sensible action should be copied nationally.

Many general practitioners are more knowledgeable about this problem than is generally realized.

Industrial medical officers play an important part in the resettlement of the individual returning to industry; the industrial medical officer often has the extremely difficult task of relating an employee's altered capacity to the jobs which are available. The detailed results of the follow-up of these cases once they are back in industry can assist the other services engaged in rehabilitation to a very considerable extent; in addition the information available from the industrial medical officer has not been fully used.

To turn now to the statutory authorities. The Ministry of Labour, under the impetus of the Disabled Persons (Employment) Act, has probably made a greater contribution to the subject of rehabilitation than any other Department by the provision of Disabled Resettlement Officers at every local Employment Office, a corps whose training has been steadily increased and improved since 1944; by its Industrial Rehabilitation Units which carry out the work of reconditioning people returning to their own or other work or assessing cases requiring a change of work or training; by its Medical Interviewing Committees which give medical advice to

assist the D.R.O. in the placing of disabled persons; by its Government Training Centres, which train both disabled and able-bodied for new vocations, and its Remploy Factories for the more seriously disabled; and by its Disablement Advisory Committees, dealing with local problems.

In recent years the Ministry of Health, particularly since the publication of the Piercy Committee Report, has advised Regional Hospital Boards, Boards of Governors, and Local Authorities to tackle the problem of rehabilitation, the problem of handicapped persons of all ages. The Ministry has issued documents to the Hospital Service, the Local Authorities, and to general practitioners on the general problems of rehabilitation, and has encouraged Boards and Hospitals particularly concerned, not only to develop, but to make the best use of existing facilities and to provide facilities for a system of planned convalescence. The streamlining of these rehabilitation services run under the aegis of the Ministry of Health could save the National Health Service millions of pounds and would reduce the demand for more hospital beds which is often made. The increased use of this new concept of treatment means a shorter hospital stay and a quicker return to work. These are basic factors in the national economy.

The Ministry of Health in a Circular to Regional Hospital Boards and Boards of Governors stated:

"Rehabilitation is not to be regarded as the application of special techniques, and still less as a separate medical or other specialty, but above all, as a constituent part of the thought and action of all those who are concerned with treating patients and the restoration of disabled persons to their utmost capacity."

In spite of this, the Ministry of Health in its circulars has tended to concentrate on a thesis of physical medicine as expressed by physiotherapy, remedial gymnastic, and occupational therapy services, rather than to demand from the medical profession the individual and collective response which is its right. It is important not to build a rehabilitation service entirely on a basis of physical medicine. Of the groups which comprise the profession, the orthopaedic, traumatic, and thoracic surgeons, the chest physicians, the psychiatrists, and the physical medicine group have shown a greater willingness to accept the additional responsibilities of treatment than others, but it is emphasized that rehabilitation is one of every doctor's fundamental responsibilities.

Both Departments have encouraged the use of resettlement clinics or case conferences at every major hospital, *i.e.* clinics in which consultant, almoner, disabled resettlement officer, and doctor with knowledge of local industry can pool their

knowledge to the benefit of the patient, but the response has been completely inadequate.

The Piercy Committee, a mainly inter-Departmental Committee, was set up by the Ministers of Labour and Health and the Secretary of State for Scotland in 1953 with the following terms of reference:

To review in all its aspects the existing provisions for the rehabilitation, training, and resettlement of disabled persons, full regard being had for the utmost economy in the Government's contribution, and to make recommendations.

The need for economy will be noted. This Committee arose from the Government's wish to ascertain what had happened as a result of the numerous legislative measures passed since the Tomlinson Report of 1943. The Committee finally reported in September 1956, after holding 54 meetings and taking voluminous evidence. In the interpretation of its terms of reference there was a significant change in the definition of rehabilitation. Paragraph 5 of the Piercy Committee's Report reads:

"The term 'Rehabilitation' in its widest sense signifies the whole of the process of restoring a disabled person to a condition in which he is able, as early as possible, to resume a normal life. With this interpretation, it would cover also training and resettlement in employment. As the terms of reference specifically mention rehabilitation, training and resettlement, the Committee decided that its use of the term 'Rehabilitation' should be confined to medical and surgical treatment designed to restore physical and mental functions, and to the process of reconditioning, designed to restore the capacity for taking up employment or vocational training. Whilst the Committee was concerned primarily with vocational training for the disabled, it decided to take account also of other forms of training of the disabled more strictly educational in content. It also decided that the term 'Resettlement' should be used to cover both the placing of disabled persons in employment (including any follow-up action to ascertain the effectiveness of the placing) and action taken to re-settle other disabled persons—such as housewives—who are not in the industrial field."

The separation of the terms "Rehabilitation", "Training", and "Resettlement" may indicate a desire to preserve Departmental tidiness, but this fragmentation tends to promote gaps when the whole process should be continuous.

The Piercy Report found omissions and deficiencies in almost every sphere and in every agency involved; deficiencies not only of personnel but also in the appreciation of the situation and its problems. Referring to administrative arrangements, the Report says (paragraph 317):

"To secure the most efficient operation of these services (from the standpoint of the individual) at the minimum

cost in manpower and money, sensitive contact and willing co-operation are necessary between the various agencies and Departments concerned. This is needed at the centre, at the local level and among the regional authorities. The Committee believes that some improvement in existing conditions at all levels may be desirable, and is attainable."

This is a most masterly understatement.

The Committee finally made 46 recommendations, covering Hospital Services, Resettlement Clinics, Regional Hospital Boards, Rehabilitation Committees, Industrial Rehabilitation, Comprehensive Rehabilitation and Assessment Centres, Rehabilitation Services provided by employers, Welfare Services, appliances and other aids for the disabled; Vocational Training, Disabled Persons' Register, Placing of the Disabled in Employment, Sheltered Employment including Remploy, Home Workers' Schemes and provisions for the young and other special categories of the disabled.

The Report was clearly a challenge to all participating authorities, but subsequent action was considerably delayed. It was not until 1958 that the Ministry of Health issued Circular H.M. (58) 57 on *Rehabilitation in the Hospital Service and its Relation to other Services*, and Circular 16/58 to Local Authorities on *Services for Handicapped Persons*. The Circular to general practitioners on *Rehabilitation of the Sick and Injured* appeared in July 1959, but was not circulated until further information as to available local facilities for rehabilitation was included as an appendix.

Several agencies, including Hospital Boards and Local Authorities, took positive action before the issue of these circulars. Indeed one Regional Hospital Board had taken in 1949-50 the action proposed by the second of the Piercy recommendations. The Regional Rehabilitation plan, evolved at that time by the co-operation of the Leeds Regional Hospital Board and the East and West Ridings Region of the Ministry of Labour, had reposed in the files of the appropriate Ministries since that time although the Chief Medical Officer of the Ministry of Health had expressed the view that this plan should be the pattern for all Regional Rehabilitation Services. It is interesting to relate that one Department denied that it had a copy of the plan.

Other Regional Hospital Boards are now engaged in an attempt to implement the recommendations of the Piercy Committee, and serious efforts are being made to improve the content of services, and to co-ordinate the various services. These efforts do not necessarily take the same pattern; for example, two adjoining Regional Hospital Boards have entirely different concepts. One believes that all rehabilitation services should be based on the

establishment of physical medicine consultants and centres at strategic points in the Region; the other Board feels that one of its basic functions is to implant the ideology and philosophy of rehabilitation into all its consultants and hospitals. The results will be watched with considerable interest.

The Future

Making the assumptions:

- (1) that hospital and general practitioner services can be improved to the extent that the responsibilities of rehabilitation are fully appreciated;
- (2) that Local Authorities accept in full their responsibilities under the various enactments;
- (3) that the various Ministries co-ordinate the work more efficiently and provide the necessary stimuli from time to time,

what remains to be done, and what should be done to anticipate the demand on other resources?

In the first place, is there the necessary link with industry to obtain resettlement? The link is probably there, but will not be efficient until there is a comprehensive Occupational Health Service in this country. Some large firms have achieved much in this sphere on behalf of their own workers, but at present their achievements cannot for numerous reasons be copied by the smaller undertakings.

There is a real need for the appreciation by all those engaged in the service of rehabilitation (both medical and lay) that entry into industry (and re-entry into industry) is no longer a slap-happy event, even although that term may still be applied to a number of school leavers.

The relationship of the functional analysis of the worker to job analysis is an essential in the resettlement of the handicapped person. The techniques concerned should not be reserved for a small number of doctors who understand how to complete an official Ministry of Labour D.P. form and the disabled resettlement officers who frequently have to try to interpret the inadequacies of the medical profession in the completion of these forms.

It is not sufficient for the almoner at the behest of the disabled resettlement officers to chase the consultant to complete one of these forms, which may then be passed on to the senior registrar, the senior house officer, and finally the junior house officer, who cannot pass it on to anyone else. The problem of equating a man's residual capacity to a particular job is often difficult, but until and unless the medical profession learns more of the pattern and reality of industry, schemes of rehabilitation will never attain the success they merit.

It may be argued that the simplest method for dealing with the problem would be to leave it to be

settled by a few trained specialists. In my view this would be entirely wrong, because the philosophy of rehabilitation and the purpose behind it must reach and be accepted by all branches of the medical profession.

The work of the industrial medical officer in this sphere would assume reasonable proportions if a much clearer link existed between the agencies of the National Health Service and industry than at present. The growing tendency of the National Health Service and the Industrial Health Service to develop separate entities with little or no co-ordination is unsatisfactory.

Rehabilitation services will expand in this country although rather more slowly than some would like; industrial medicine and occupational health will grow, perhaps more quickly, under the stimulus of knowledgeable and visionary Ministers of Labour and Health, but they will never be complementary to each other until doctors in the consultant and general practice services fully comprehend what employment or work actually means; what industrial processes demand, and, not least, that work therapy in the actual course of employment can contribute a great deal more to the national economy and the worker's personal happiness than hours spent weekly doing elementary exercises in a hospital physiotherapy department. Nothing is more tiresome than to see the constant reference of people to hospital for exercises which can be done, and indeed are done, in the active performance of their ordinary work, and this wasted time must stop.

The responsibilities of industry are great, because it must be impressed on the curative services of this country that the end result of all their efforts is work, and work as quickly as possible; the social aspect will follow.

Employers and workers alike must not put barriers in the way of resettlement of handicapped or disabled persons. The limitation of jobs, the demarcation of jobs, the petty differences, the lack of liaison between trade unions in relation to a man's change of job—all these must be overcome in the knowledge that most disabled persons can contribute a full day's work and in the need to return the worker to proper employment and his social environment.

The industrial medical officer has a special responsibility for initiating schemes of liaison within his own establishment. It is part of his normal function, but it is sometimes neglected. Also he has a most important role in attempting to educate his professional colleagues about the actual performance of processes which are merely names to the majority of doctors, and in the elimination of the term "light work".

The Piercy Committee reported that:

"Employers can—and in many cases do—take steps to modify the conditions or tempo of employment so as to enable the disabled person on return to employment after illness and injury to accustom himself more gradually to industrial conditions."

Yet there are instances where an almoner has contacted an employer in relation to a person who has had a severe illness or injury and has mentioned "light work". Such a patient usually gets light work, and, in the absence of an industrial medical officer, often remains at the menial task supplied by the use of this archaic term. This fault is not confined to almoners.

The statement made at the seventh World Congress of the International Society for the Care of Cripples by David A. Morse—Director General of the International Labour Organization—is of the greatest importance:

"We all recognize that rehabilitation is not an end in itself, but only a means to an end. Its purpose is to change the disabled person from a state of dependence to one of independence, from disability and helplessness back to ability and usefulness at work. Resettlement in employment then is the crux of the whole process of rehabilitation."

Historians tell us that one of the greatest achievements of mediaeval Christendom was its success in making work socially satisfying. Nowadays, we seem to have lost the impetus of a faith. By the acceptance of a dynamic philosophy in relation to rehabilitation, we can really make work socially satisfying.

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