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### Abstract

Based on a Dissertation read before the Royal Medical Society on Friday, 23rd October, 1964

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# REHABILITATION SERVICES FOR THE INJURED

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Not until the start of the 20th century did the organisation of rehabilitation services on a comprehensive scale develop. In this, Britain played a leading role largely due to the influence and leadership of one great man—Sir Robert Jones. Robert Jones was selected in the 1890's to organise the first unified accident service in Great Britain, which was set up to deal with the injuries sustained by the large body of men employed in the construction of Manchester Ship Canal. The social conscience of the time did not include rehabilitation per se in the accident service, but the experience gained there by the young surgeon bore fruit in the First World War when as a famous orthopaedic surgeon, he was given the task of organising special military hospitals with full rehabilitation facilities.

In 1915 he established an orthopaedic centre at Alder Hey, Liverpool and there he stressed the vital importance of follow-up and deplored the movement of patients from hospital to hospital. He had this to say in a famous letter of 1916: "There is also a want of cohesion between departments of treatment, such as massage, physical exercises, electricity and manipulative and operative groups of cases, all of which properly controlled make for success in orthopaedic surgery. It appears to me that we want one large orthopaedic hospital combining all these departments, and staffed by expert men under a director, who should be the final arbiter as to the conduct of treatment." As a result of this letter, Hammersmith Workhouse at Shepherd's Bush was authorised in 1916 as a hospital for orthopaedic cases and became the

first experimental hospital in training the disabled. In his "curative workshop" he stressed the importance of work having a direct curative bearing upon the recovery from injury and he also said, "we depend largely upon the psychological element to help in the recovery."

At the end of the war, the country was faced with the problem of training disabled ex-servicemen and to meet their needs the Ministry of Pensions set up Government Instructional Factories in 1917. These were transferred to the Ministry of Labour in 1919 and have become the Government Training Centres of the present day. Also in 1919 the King's National Roll was created—a scheme whereby employers who took on a quota of disabled ex-servicemen received a preference in the allocation of Government contracts.

Between the Wars, interest in rehabilitation continued as indicated by the 1935 British Medical Association "Committee on Fractures" and the 1939 Delevigne "Inter-Departmental Committee on the Rehabilitation of Persons Injured by Accidents". About this time, two training colleges were established to train any (not just the young) disabled with a view to placing in employment.

Under the impetus of War in 1939 it became obvious that the utmost use of all available manpower was essential and an Interim Scheme for Training and Resettlement of the Disabled was started in 1941. In December of that year, an inter-departmental committee on the rehabilitation and resettlement of disabled persons was appointed under the chairmanship of Mr. G. Tomlinson, M.P. After careful and thorough deliberation, the "Tomlinson Report" was published in January, 1943.

It emphasised that 'rehabilitation in its widest sense is a continuing process' which has two aspects, the Medical and the Social or Industrial. The report drew attention to the need for close co-operation between Health and Industrial Services, with continuity of care as the patient passes from one service to the other. 'Ordinary employment', the goal for all the injured is practicable for the majority. Only a minority require sheltered conditions and these should be provided by the government.

The Report also recommended that a Standing Joint Committee of the Government Departments mainly concerned—those of Education, Health, Labour, etc. be set up for the supervision of administration of the scheme; and this was immediately appointed.

As a direct result of this report, the Disabled

Persons (Employment) Act of 1944 was passed which made provision for a Register of Disabled Persons superseding the King's National Roll, and firms which employ over twenty persons must take at least 3% of their staff as registered disabled. The Act also required the Ministry of Labour to make better provisions for enabling disabled persons to secure employment and empowered the Minister to appoint officers to act for the purposes of the act—that means, it created the D.R.O. (Disablement Resettlement Officer) service of which mention will later be made.

After the end of the War—in 1946—began the social legislation planned during the war period in the "Survey of the Inter-Departmental Committee on Social Insurance and Allied Services" under the leadership of Sir William Beveridge. The National Health Service Act in 1946, then the National Insurance Act in 1946 which provided sickness and unemployment benefit, retirement pensions and maternity benefits; the Industrial Injuries Act 1946 which superseded the Workmen's Compensation Acts, and finally the National Assistance Act 1948 which marked the end of the Poor Law and the start of a new social welfare code.—This was the fundamental legislation.

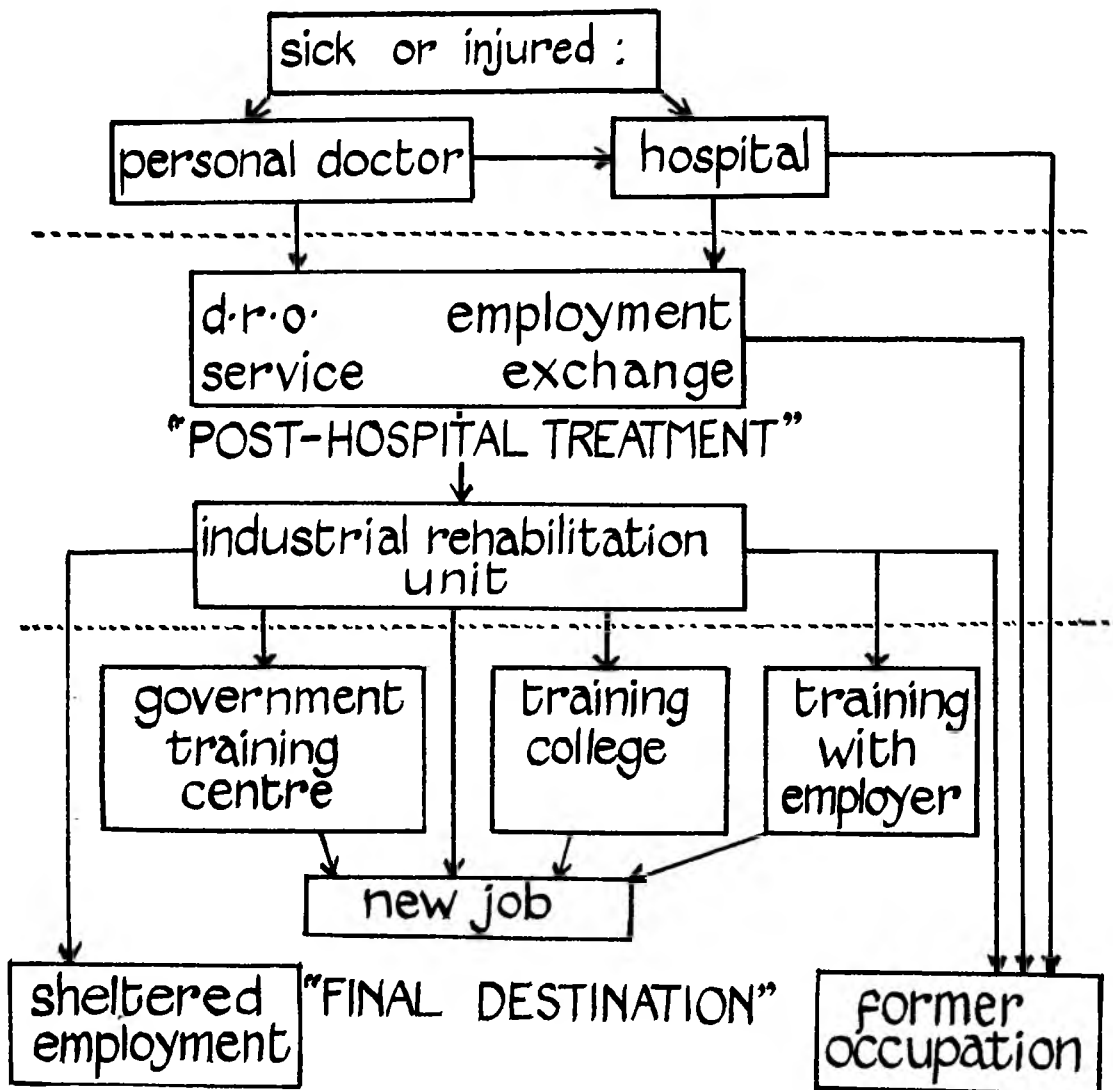
In 1953, another committee, under the chairmanship of Lord Piercy, was set up "to review in all its aspects the existing provision for the rehabilitation, training and resettlement of disabled persons." The Piercy Report was published in 1956 and the conclusions were that the facilities enabling the disabled person to get suitable employment were comprehensive and well-established, needing little change; that since 1944 there had been a widening and deepening of the concept of rehabilitation on the medical side; and in general the completeness of statutory provisions which existed for services for the disabled was impressive. A few recommendations requiring legislation gave rise to the Disabled Persons (Employment) Act 1958 and the committee emphasised most strongly the need for complete co-operation between the various services.

Just what are the services available to-day, and how are they in fact used?

An outline of the scheme should be considered as a whole Diagram opposite.

Most patients with serious injury are treated in hospital and the trivial injury which can be treated by a G.P. seldom gives rise to problems in rehabilitation. Therefore, the hospital facilities deserve consideration. In a large

# "MEDICAL CARE"



general hospital there is usually a physiotherapy department, an occupational therapy department and an almoner service to help the consultant with the rehabilitative care of his patients. But the ultimate treatment rests with the consultant surgeon, and the activity of the rehabilitation team will depend largely on his enthusiasm and outlook. Most consultants

now are very good in this respect and pay a great deal of attention to the ultimate goal in planning treatment.

## HOSPITALS

Often the stay in the acute accident centre is short so that only the initial rehabilitation work is carried out there, the later and more

vigorous rehabilitation taking place in a convalescent type of hospital. As an excellent example of this latter type, the Astley Ainslie Hospital in Edinburgh can be mentioned. The object is "total medical care" and patients referred after primary treatment in some other hospital (usually Royal Infirmary of Edinburgh) are in general not discharged till they are "completely rehabilitated". To achieve this object, use is made of an O.P. Physiotherapy Department and an O.P. Occupational Therapy Department which runs some unique facilities. There is, in the hospital grounds, a "home unit"—self-contained premises run by the O.T. department for training in use of toilets, bath, dressing, cooking etc. Patients can live in this unit for short periods and their capabilities can be fully assessed. This extremely valuable service is also available for patients referred by the G.P.

Also on the grounds is a mining rehabilitation unit, complete with simulated coal face, conveyor belt, and hutchies; which allows miners to work for some considerable period under fairly realistic conditions in order to determine their capacity to return to former employment.

The "home unit" is perhaps of special value, as it provides training facilities not available under any Government Scheme for a sizeable group of patients otherwise largely neglected.

Another special hospital is that of Edenhall, Musselburgh, which in 1959 was started as a 5 year pilot scheme for long term treatment of paraplegics. This hospital of 28 beds admits about 30 new cases per year with an average stay of 9 months. The re-employment rate of discharged patients is low—only 10%, but it must be remembered that:

- (1) paraplegia is a very severe disablement
- (2) earning capacity is therefore limited
- (3) victims of industrial injury may collect up to £15 per week compensation
- (4) delay in settlement of claims for damages may effect the desire of a patient to start work.

Though a small proportion of the injured, paraplegics deserve special mention as they present challenging problems in rehabilitation at all levels.

#### D.R.O.

Now the D.R.O. Service can be examined. In many ways, the disablement resettlement officer is the key man in the Government Scheme for he is in contact with the hospitals, the G.P.'s, the I.R.U.'s, the Training Centres and the

employers and he also (and most important of all) takes a personal interest in every patient. The C.R.O. is primarily a civil servant, an employment officer of some experience with special interest in the disabled. His main task is the placing in employment of disabled persons who have difficulty in finding work; most of these people are on the Disabled Persons Register, but the D.R.O. also assists a number of persons who are not so registered. Registration is voluntary, but a person must be likely to be disabled for at least 12 months, yet not be so severely disabled as to be incapable of remunerative employment either in open industry or in sheltered conditions. In small employment offices, the D.R.O. is often part-time and he may be, for example, the manager of the same office. The work done by these men is of very great value and there is no doubt that it is their personal character and their close personal contacts with both the medical profession and the employers which enables them to fulfil their vital role. The efficiency with which the service works is a tribute to the enthusiasm of the men in it.

#### I.R.U.

The Industrial Rehabilitation Unit at Granton is one of 17 such units in Great Britain and like the others it has two main functions—

- (1) Assessment of the patient's aptitude for various types of work,
- (2) "Toning-up," both physically and mentally, for return to the conditions and tempo of full-time work.

Patients work regular hours throughout the week at jobs under contract from various firms—the work must therefore be finished on time and so the patient is under a certain pressure and at the end of the course they can have confidence that they will be able to do a normal day's work.

There are 90 patients at Granton with an average stay of 8 weeks. They travel into work every day, but there is also resident accommodation for those who live too far away. Referral is from hospital or G.P. via the D.R.O., there is a waiting list of 150 patients at the present time (Summer 1964).

On average, 15 new patients attend every week. Within the first two days each newcomer is seen by the Supervisor; the unit doctor who examines the patient and recommends any special diet or exercise required; the psychologist who gives personality, intelligence, and aptitude tests; and by the social worker if necessary

to help sort out financial or family troubles. After these interviews a conference is held and the potential of the patient judged—this is confirmed by his progress in the workshop under the workshop supervisor. After one week another conference is held and each patient reviewed in the light of progress reports; on performance basis the date of next review is decided. In this way the programme is "tailor-made" to fit each individual and if there are signs that progress is not as expected the patient can be given some other job. At the end of the course, the last conference is held to decide on the final report to be sent to the D.R.O. about the type of employment which would suit the patient. It is the D.R.O. who must then place the patient or arrange for further training.

Follow-up 6 months after completion of the course is made by letter, and most patients reply with details of job, pay etc. A wide range of patients is accepted at the I.R.U., the largest single group—22% comprise the psychoses and neuroses. Injuries account for about 20% of the patients and this group enjoys the highest proportion (70%) in work or accepted for training within 3 months of completion of the course.

Vocational training is not given at I.R.U.'s, but if assessment at an I.R.U. suggests that a patient requires such training, he may be able to attend a Government Training Centre. There are 22 of these in Britain, and 4 Residential Training Colleges which provide courses in a wide variety of trades lasting from 26 to 52 weeks, according to the trade. The Ministry also will make provision for training at technical and commercial colleges in appropriate cases.

### SHELTERED WORKSHOPS.

The Ministry is not directly responsible for running any sheltered workshop, but it has close links with Remploy which employs over 6,000 severely disabled in some 90 factories throughout the country. It also provides financial assistance towards training, trading losses and capital expenditure to Local Authorities and voluntary organisations running sheltered workshops, who, between them, provide work for about 5,000 disabled persons.

There are two excellent voluntary organisations here in Edinburgh, The Simon Square Centre and the Thistle Foundation.

The Simon Square Centre began in 1902. It is a voluntary organisation but acts as the agent

for the Local Authority to comply with the provisions of the National Assistance Act of 1948 and so in an indirect way receives some Government support. In Simon Square, sheltered work is undertaken by about 113 severely disabled, looked after by Social Workers and Occupational Therapists. Injuries are very little in evidence, most patients being chronically disabled arthritides, victims of C.V.A., D.S. and epilepsy. But Simon Square is very much more than a sheltered workshop, it has recreational facilities, social clubs, lunch clubs and in fact provides an extremely valuable and lively social service for the community. The most striking thing about the centre is the terrific atmosphere of enthusiasm and gaiety which diffuses from the staff to all who attend the centre.

The "Sheltered Workshop" is again a mere fraction of the Thistle Foundation. Incorporated in 1944, its main object was to provide better care and treatment of severely disabled ex-servicemen in Scotland than was made after the First World War. This it achieves in a truly remarkable way—there are about 100 self-contained houses, specially built and designed for the convenience of the disabled person, grouped round a fully equipped clinic. Most of the houses are four apartment, and all incorporate ground-floor bathroom, toilet and patient's bedroom, as well as living room and kitchen. As each house is private and self-contained every patient must have someone living there to look after him and indeed most of the patients are married, some have relatives to care for them, and one or two manage to get a married couple to live in. The whole idea is that the disabled man leads as normal and independent a life as possible. In the clinic building there are O.T. and Physiotherapy departments, a small pool for hydrotherapy, a large gym and a small sheltered workshop where a few of the men are occupied on knitting machines making hose-tops for Highland Regiments. The range of social and sporting activities and the enthusiasm of the staff and patients are impressive. Quite often a man comes there with little hope of ever living an independent life—the problems of coping with severe disability have often caused mental resignation and overwhelming self-pity has killed the desire to overcome the disability. Within the atmosphere of this foundation, however, they find a new inspiration, a change of outlook and a desire to be independent as they learn how to come to terms with their new life.

The main weakness in the present scheme is the delay between hospital and post-hospital care. A delay of six weeks at this critical period is common, and during this time no organised rehabilitative measures are ensured in any way. Closer contacts between the hospital and the I.R.U. are obviously desirable, and an exercise in collaboration between a General Hospital and an I.R.U. was reported by Fletcher and Wheble in the B.M.J. of January, 1964. By this method, the average time between injury and attendance at I.R.U. has been halved in nearly all cases. An even more interesting plan is that for a comprehensive centre planned at the Belvidere Hospital in Glasgow where the I.R.U. is to function side-by-side with the medical rehabilitation centre.

### SAIGHTON CAMP

No civilian scheme will ever work as efficiently as the Army Medical Rehabilitation Unit at Saighton Camp, Cheshire. It was established as A.M.R.U. in 1957 and is the only one for the whole British Army. It holds 150 patients with an average stay of 12 weeks, after which time 80% are completely fit for return to unit. About 10% are discharged the service as unfit for active duty. Most common injury in the army is, of course, sporting injury, next road

accidents—"bullet trouble" accounts for a very small percentage at present! Typical of the cases they treat is the torn meniscus—10 days after meniscectomy, the man has his stitches out and is sent straight to A.M.R.U., there he will perform graduated exercises from 9 a.m. to 5 p.m. for about 8 weeks under the supervision of specially trained P.T. Instructors—not slim physiotherapists, but muscular athletes. At the end of this time the man is fitter than the average civilian will ever be in his life!

The statistics for rehabilitation from this camp are staggering but the staff to patient ratio is 1 : 10, the average age of patients is only 20 years, the group is artificially selected by being accepted for the army in the first place, and the patients are under army discipline all the time.

This article has attempted to explain a little of the meaning and method of rehabilitation, and to suggest how the present good system could be improved.

The most important individual in this scheme is, and always shall be, the patient. And it is the duty of all who come into contact with him to remember the goal of treatment — independence. Only by bearing in mind the meaning of this word for each individual will one succeed in treating the whole of the patient, not put the hole in the patient.

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