EDITORIAL

THE DISABLED AND PHYSIOTHERAPY - THE FUTURE?

During 1981, the International Year of the Disabled Person we have all been aware of the disabled, their problems and their needs. Professional bodies, voluntary groups, the business and public sectors all highlighted various aspects, pledged and gave generously in time, service and support. The disabled themselves, individually and collectively, participated in events and made their needs known. What have we learnt and where do we go from here? How do we physiotherapists figure in the future?

Physical disability brings social alienation (Hislop, 1976), and, according to Darwin, adjustment and adaptation to the environment is essential for survival. Physiotherapy has a meaningful role supplying the means of adaptation which can ameliorate disability and improve the quality of life. Since the disabled have to meet normal needs in abnormal ways, jobs, transport, education, and the like have to be modified for regular access. Their resolve for self-determination is as strong as or stronger than that of the society, often feeling little obligation, on whom they are dependent. The greatest penalty of physical disability is possibly the conflict between dependency and aggressiveness, frustration and enterprise, and the physiotherapist, by understanding these consequences, can assist the patient to adapt personal priorities and perspectives in order to achieve a mode of performance and style of living that will exact the least penalty over the years.

The disabled have expressed acute physical and psychological shock after extensive trauma such as spinal cord injury (Joubert, 1980) and highlighted the special needs for accommodation, care and employment in order to become once more worthy contributing members of the community, often after long and arduous rehabilitation. Since physical dependence could lead to isolation, communication is of major importance to maintain and enhance social interaction.

Society often has negative and ambivalent attitudes to physical disability, which is equated to mental, emotional and intellectual disability, leading to inequality in encounter. The disabled need to be prepared for this during rehabilitation by encouraging positive self-image, self-respect and self-communication, which in turn will enable them to communicate their situation to others and to establish new behaviour methods. Thereafter the initiative rests with the disabled to make contact, ask for help, explain his situation, listen attentively, accept the wheelchair as a reality and become involved in community services. They should be encouraged to express their feelings and more attention could be given to sexual adjustment and problems. Openess, love, honesty and mutual respect for the situation of each other will improve communication.

Kenedi (1980) feels that the Mair Report of 1972, which defines rehabilitation as the restoration of the patient to the fullest physical, mental and social capability, probably satisfies the widest scope, but Agerholm in 1979 probably expressed it more specifically as normality of abnormality, since most handicaps and impairment are not temporary. He further defines the rehabilitation clinic team as the **patient** and a diagnostic and treatment group who can effect solution(s) of the patient's problems. This implies that every member is a professional and of equivalent collaborative status, not supplementary, superfluous or subservient. Mutual respect, authority and status relevant to function are essential characteristics of the team. Various studies have been made to evaluate cost effectiveness of rehabilitation, but there are many unquantifiable factors such as human suffering or pleasure which are most important in the success or not of rehabilitation. It also seems to be more productive in the domestic rather than the industrial sphere, for example assisting older women to achieve functional independence rather than retraining young men after trauma; rehabilitation for retirement rather than employment; overcoming minor problems in self-care and mobility rather than helping the severely disabled to achieve functional improvements. The professional is the kingpin and rehabilitation can be viewed as a total concept or as a series of specialities. Specialty compartments seem to be barriers to effective rehabilitation, as are shortage of time, competition for time and space with acute services, inadequate social and functional support, lack of glamour, severe/multiple complications suffered by patients, lack of scientific method and fear of adequate delegation to non-medical team members.

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Kenedi defines a professional as a person who receives objective input (measurable data such as temperature) as well as subjective (intuitive) input, which combine to form a recognisable pattern, can be classified and used for diagnosis and treatment selection. Education and training influence both inputs, but especially subjective input and pattern recognition. The modern concept of degree education accepts that practical and vocational aspects are incorporated (cf medicine and engineering) and could only enhance the creation of an environment that encourages the development of intellectual and imaginitive skills and powers. Such an education (basic or postbasic) should not only increase knowledge, but should also stimulate an enquiring, analytical and creative approach with independent judgement and critical self-awareness which can see relationships and relate to actual situations with informed awareness of factors influencing social and physical environment.

To date physiotherapy has developed mainly practically, with little or no systematic evaluation of its effectiveness (Partridge, 1980). Physiotherapists now have the academic background and financial support to accept the challenge to instigate and undertake investigations. Cooper (1981), suggests that physiotherapists stop pleading ignorance of skill to conduct investigations, but rather set their own parameters and play with statistics in order that objective fair trials are set up, so that physiotherapy is no longer relegated to the ranks of expensive nonsense contributing little to treatment.

Partridge warns of the difficulties since treatment is a dynamic process with interaction between therapist and patient, with individual approach, methods and management, all influenced by the therapist's skill and experience and the patient's reaction to his condition, the therapist and treatment. She suggests that diagnoses/conditions referred for physiotherapy be grouped in four main groups; associated prognoses and natural history, broad aims of treatment and focus of outcome be defined; careful assessment, monitoring and measurement will then supply some factors for evaluation.

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