

## **Rehabilitation measure for the manual for cancer services**

### **Response of the British Society of Rehabilitation Medicine (BSRM) and the Joint Specialty Committee of the Royal College of Physicians**

The BSRM and Joint Specialty Committee for Rehabilitation Medicine appreciate the opportunity to comment on this draft document and would like to highlight the major gap, which is a failure to link into specialist rehabilitation services, by commenting on four general areas: -

1. What is meant by the term rehabilitation
2. The need for specialist rehabilitation professionals/teams
3. The need for vocational rehabilitation, with inclusion of specialist medical expertise within the multidisciplinary process
4. Specialist rehabilitation services– and in particular, recognition of medical involvement in specialist rehabilitation

1. Current concepts of rehabilitation are given in Appendix 1, together with an outline description of the specialty of Rehabilitation Medicine.

2. Your introduction defines rehabilitation in terms of the services offered by the four Allied Health Professions (AHPs), which is restrictive. These services depend on rehabilitation professionals working in teams, supported by trained rehabilitation physicians. Your document acknowledges that palliative care services are provided by appropriately trained teams but fails to recognise the similar specialist medical component in rehabilitation services.

Whilst cancer services are ably supported by cancer and palliative care specialists, few have appropriate experience in preventative, supportive and rehabilitation treatments that your document acknowledges are needed. The National Service Framework for long term conditions outlines the potential of rehabilitation services to provide such support for those with static, improving and deteriorating conditions<sup>1</sup>.

The BSRM recognises that not all health localities have access to a consultant in Rehabilitation Medicine, but where such individuals exist, the cancer rehabilitation group would benefit from their input and, in places, are already benefiting. The 4 level model describing care and therapy input in this draft document is not currently used within specialist rehabilitation services but with careful thought a 3 level model could be developed easily with reasonably tight definitions, allowing easy identification of shortfalls in provision.

3. Whilst most localities will have access to palliative care services, services for those whose cancer is in remission or cured may benefit from the skills of rehabilitation teams that are skilled in assisting sick or disabled individuals to be totally reintegrated in society, including the world of work.

It is widely recognised that the biopsychosocial model of care is needed in all complex rehabilitation provision and this requires knowledge of medical, surgical, environmental, physical and psychosocial interventions; and knowing how such interventions can be integrated to minimise disruption to individual patients' lives. There are also complex inter-relationships with the worlds of education, employment, social work and the charitable sector which are not alluded to within your documents.

It is also widely recognised that for working-age people the end result of a health intervention should often be a return to employment: -

*“the crucial relationship between work and health dictates that the ultimate outcome measure of success in the clinical treatment of working age people should generally be remaining in, or returning to, work”* ( Draft Consensus Statement on Health and Work – Dame Carol Black – personal communication).

4. It follows that cancer rehabilitation services should have access to rehabilitation professionals with the skills to advise on the relationships between work and health. The skills needed to maintain an individual in employment in the presence of ill health or disability have recently been outlined<sup>2</sup>. It is also widely recognised that vocational rehabilitation begins at the beginning of an episode of care and is not a 'bolt-on' at the conclusion of therapy<sup>3;4</sup>. Recognising that the outcome of treatment is never easy to predict, cancer teams will need to be subtle in keeping the employment 'door open' by encouraging patients to remain in contact with their employer, and considering the use of 'disability leave' if appropriate<sup>5-9</sup>. Those who lose their job as a result of their cancer can be encouraged, when their condition is appropriate, to consider returning to the world of work, either part time or full time; and they may be able to consider working in their old position but with modified work, or in a new position with either their old or a new employer. Rehabilitation Medicine is a source of medical expertise within the framework of multidisciplinary vocational rehabilitation.

The documents make no mention of pre-existing specialist rehabilitation services but cancer rehabilitation teams will need to work harmoniously with: -

- Community rehabilitation teams
- Environmental Control Unit services (for those with severely impaired hand function)
- Musculo-skeletal services
- Neurological rehabilitation services (for those with involvement of the brain, peripheral nervous system or spinal cord)
- Orthotic services (for those needing custom made devices)
- Prosthetic services (limb cancers requiring amputation)
- Vocational rehabilitation services
- Wheelchair services (Mobility issues)

Here, a developed relationship with Rehabilitation Medicine is essential. Best use of these specialist resources will be made by carefully identifying need and allocating the most appropriate resource, avoiding the restrictive practices that can occur when resources are tied down to a diagnosis rather than being used generically.

This response has been drawn up by Dr Andrew Frank (Past President), Professor Chris Ward (President) and Professor Christine Collin (President elect) on behalf of the British Society of Rehabilitation Medicine and the Joint Specialty Committee of the Royal College of Physicians.

## **Appendix 1 – Current views on rehabilitation**

Rehabilitation is defined in terms of both concept and service.

**Conceptual definition:** a process of active change by which a person who has become disabled acquires the knowledge and skills needed for optimal physical, psychological and social function.

**Service definition:** the use of all means to minimise the impact of disabling conditions and to assist disabled people to achieve their desired level of autonomy and participation in society.

Derived from <sup>10</sup>

**Rehabilitation Medicine (RM)** is a medical specialty providing medical management and technical assistance for people with complex disabilities arising from neurological or musculoskeletal impairments, including neoplastic lesions. RM specialists have the knowledge and skills to confirm diagnoses and prognoses, prevent and treat secondary complications, manage symptoms, facilitate treatment and contribute to life decisions. They also provide information, support and counselling for patients, families, and carers. Most RM consultants lead and co-ordinate the activities of a multi-disciplinary rehabilitation team (based on Working for Patients <sup>11</sup>).

Reference List

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- (5) Correspondence. Vocational rehabilitation. *BMJ* 2001; 323(eletters 22 July):1-8.
- (6) Miller S. Working with MS: a guide for employees and employers. London, Multiple Sclerosis Society, 2000.
- (7) Paschkes-Bell G, Da Cunha S, Hurry J. Adapting to change. London, Royal National Institute for the Blind, 2007.
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- (9) Royal National Institute for the Blind. Adapting to change when an employee becomes disabled. London, RNIB, 1996.
- (10) Turner-Stokes L. Rehabilitation following neurological injury. *Horizons in Medicine*. No 18 ed. London: Royal College of Physicians; 2006. pp133-142.
- (11) Royal College of Physicians. Working for patients. London, RCP, 2007/8