REHABILITATION: BALANCING PERSPECTIVES; EXPLORING THE CONCEPT

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1. INTRODUCTION: GETTING AN EVERYDAY FIX ON REHABILITATION

Let's start with an easy to remember definition:

"Rehabilitation is a problem-solving, educative and collaborative process aimed at restoring well-being and independence" (adapted from Watson, 1998).

Why train rehabilitationists to undertake rehabilitation? For my money, it is to reduce disability, distress and the barriers resulting from impairment and disfigurement.

Arokiasamy (1993), defines rehabilitation as:

"An holistic and integrated programme of medical, physical, psychological, psychosocial and vocational interventions that empower a disabled person to achieve a socially meaningful and functionally effective interaction with the world, and a requisite level of personal autonomy".

He sees the goal of rehabilitation as autonomy rather than independence or empowerment i.e. enabling a client to make workable choices in their own life. Such a goal frees rehabilitation from the often-voiced scourge of paternalism.

Overview

This essay explores the three components for progressing our work as rehabilitationists:

- outlining the systems that define practice
- how to expand the knowledge-base and,
- focusing on people

Rehabilitation amounts to a unique way of looking at recovery and non-recovery. We come to rehabilitation largely through craft schools and life experience and see dysfunction and adaptation to less than perfect circumstances in a constructive and

global way that reaches beyond the bounds of distinct health and social disciplines.

What is it that distinguishes rehabilitation from the activities within discrete health and social services? Rehabilitation has a vast scope of practice and unique focus, calls for extraordinary personal qualities in the practitioner and requires a broad grasp of the human condition, its variability and what influences the human response to challenge. What makes an outstanding rehabilitationist may be as much to do with personal growth and emotional maturity, as with professional accolades.

How rehabilitation is assessed for its contribution to overall healthcare will depend upon the perspectives taken by the assessor: be it the funder, employer or consumer. Funders will grade compliance through a dazzling array of outcome measures of efficiency and effectiveness, accreditation and form filling.

Employers want registrable craft qualifications, codes of conduct, and assurances of safety and cost containment. Service users take for granted such assurances of quality and are more likely to judge performance on the personal attitudes and qualities of the rehabilitationist. Appendix 1 outlines some of the structural issues of concern to people with disabilities. These are expectations that go far beyond any one distinct clinical discipline. The New Zealand Disability Strategy (2001) further underlines these consumer views while emphasizing a 'social' perspective.

Thus, rehabilitation becomes more understandable if viewed, not only from an individual/medical perspective, but also from a social/political dimension.

As rehabilitationists delivering a unique service, we will succeed only when we have the objectivity, technical competence and interpersonal skills that enable us to listen with our hearts and minds to the life stories of those we seek to serve. When delivery systems are in place that foster professional collaboration and client interests. When we have the courage and knowledge to deal with the real problems and barriers barring success, and when those barriers are not entirely located within the characteristics of the client. Do you remember Glenn Hoddle, the sacked English football coach who saw impairment and disability as a retribution for past sins, a stereotypical belief more commonly held than might be thought in a multi-cultural society?

We need the time to immerse ourselves in the daily lives of clients, to understand the 'off-line' challenges, the fatigue and bothers of impairment. Intervention is directed at the person rather than disease, organ or symptom. People cannot be understood by reducing them to their parts.

We are about encouraging people to disconnect from a culture of damage and wounds, and to reconnect with an inner spiritual energy of purpose and meaning. Fringy stuff?! Well, the reality is that *people rehabilitate themselves* with the help of others, sometimes including professionals and that is a confounding variable in measuring rehabilitation outcomes. This is not to diminish the impact of scientific inquiry and technical competence of rehabilitationists; it is simply to state the obvious. It is the client who dictates the nature and timing of recovery. Nonetheless, rehabilitation is an investment for society rather than a cost.

The dictum of Hippocrates, the father of rational medicine, is as valid today as it ever was:

"Our natures are the physicians of our diseases".

The 19th century physician Sir William Osler put it this way:

"It is better to know what sort of patient has the disease, than what disease has the patient".

2. SYSTEMS AND CONCEPTS GOVERNING REHABILITATION PRACTICE

La Grow (2001), has described the purpose and process of rehabilitation within the contemporary NZ context, identifying that process as involving assessment, planning, intervention, evaluation and follow-up. Medical, social, vocational, case-management and consumer models of rehabilitation all utilise this process to meet their various goals. These service models may use different interventions, service providers and systems of delivery, however, the process and purpose remains the same, as do the populations served, namely, persons with a disability.

In New Zealand, persons with disabilities have been defined as those with "any limitation in activities of daily living resulting from a long term condition or health problem" (Disability in New Zealand, 1996/97). Disabilities may be physical, psychiatric, intellectual, sensory or age-related, (or a combination of these), (Health and Disability Services Act, 1993), and refer to a long-term limitation in function only (i.e. must continue for at least six months). Thus, those services designed to restore temporary functional loss may be thought of as being more related to recovery and treatment rather than rehabilitation per se.

Injury Prevention, Rehabilitation and Compensation Act, 2001

The Injury Prevention, Rehabilitation and Compensation Act, 2001, (IPRC Act), defines rehabilitation as:

> "(A) a process of active change and support with the goal of restoring, to the extent provided under section 70, a claimant's health, independence, and participation, and
> (B) comprises treatment, social rehabilitation, and vocational rehabilitation".

The new Act, which came into force, 1 April 2002, has as its primary goal:

> "Achieving an appropriate quality of life through the provision of entitlements that restores to the maximum practical extent, a claimant's health, independence and participation" (ACC Workplace Cover; Employer Information, 2002).

There are three changes to vocational rehabilitation under the new Act:

1. All employers must take practical steps to assist in an injured employee's vocational rehabilitation. This applies when the employee is returning to the same job with the same employer, and is applicable to workplace and non-work injuries.
2. Vocational rehabilitation for claimants that are not able to return to the job they had before the injury must include:
   - an initial occupational assessment to determine suitable work types for the claimant based on their transferable skills; and,

- an initial medical assessment to consider whether the types of work identified in the initial occupational assessment are suitable for the claimant.

3. Work capacity or work rehabilitation assessment is now called Vocational Independence Assessment. The Act specifies that a claimant must now be assessed as to whether they have a capacity to undertake work for 35 hours or more a week (previously 30 hours).

A Code of Claimant's rights will set clear expectations for both ACC staff and claimants as to standards of conduct; will define what constitutes a breach of the code; and will provide a basis for enforcing the code, and any remedies.

The definition of an accident has been refined to clarify that there is cover for injuries due to the application of external force (including gravity).

The schedule of occupational diseases that qualify for cover without proof of causation has been updated.

Disability Issues

From July 1 2003, a new office of Disability Issues will be set up within the Ministry of Social Development. The office will give policy advice on disability issues, lead the Government implementation and monitoring of the NZ Disability Strategy, and report directly to the Minister for Disability Issues. Six full-time staff will be employed initially.

International Classification of Functioning

In May 2001, the World Health Organisation approved a final version of the new International Classification of Functioning, and assigned the acronym ICF. The ICF succeeds the ICIDH, the International Classification of Impairments, Disabilities and Handicaps. During the revision process, various versions were discussed under ICIDH-2, an acronym now abandoned. The ICF has moved on from 'consequences of disease', as in the ICIDH, to a classification of human functioning and disability. It takes a neutral stand with regard to aetiology, so that research can more freely explore the causal factors and relationships between different aspects of the ICF.

One umbrella term is Functioning, which covers body function and activity, as well as participation. Another is Disability, which is used to mean impairment (of body function and body structure), activity limitation and participation restriction. Thus, we are having to modify our use of the word disability, which in the ICIDH referred only to limitations on the individual level. It should be noted that while functioning is an overall term, body function is used to mean physical as well as psychological functions on an organ level. It is important that we become familiar with the new uses of these terms.

Thus, the environmental dimension has been recognised in the revision. The new definition includes the following:

- Impairment is a loss or abnormality of body structure or of a physiological or psychological function.
- An Activity is the nature and extent of functioning at the level of the person. Activities may be limited in nature, duration and quality.

- Participation is the nature and extent of a person's involvement in life situations in relation to Impairments, Activities, Health conditions and contextual factors. Participation may be restricted in nature, duration and quality.

Functioning and disability are viewed as a complex interaction between the health condition of the individual and the contextual factors of the environment as well as personal factors. The picture produced by this combination of factors and dimensions is of the person in his or her world. The classification treats these dimensions as interactive and dynamic rather than linear or static. It allows for an assessment of the degree of disability, although it is not a measurement instrument. (http://www3.who.int/icf/icftemplate.cfm)

Principles of Rehabilitation

Arokiasamy (1993) has identified ten principles that offer some substance to the rehabilitation process. Summarised, these principles are as follows:

1 Every person should have freedom of choice. This freedom is to apply to the entire process of rehabilitation including assessment, planning, intervention, evaluation and follow-up.
2 Rehabilitation should make available to its clients all pertinent information in the most comprehensive manner to promote informed choice.
3 In addition to providing information, the process must be open to the reception of information from the client and his or her family, making every effort to use this information in treatment planning. An equal partnership with the client is implied.
4 The ultimate purpose of rehabilitation is the achievement of the individual's goals of autonomy, independence and quality of life.
5 Rehabilitation should pursue a holistic approach to intervention that includes physical, social, environmental, cultural, financial, familial, educational, residential, and vocational requirements.
6 Ideally, rehabilitation should involve a multi-disciplinary/interdisciplinary team. The team to include the client, the family and significant others.
7 In its assessment and treatment, the team should focus on both strengths and weaknesses, abilities and disabilities, as well as environmental resources and barriers.
8 Each client and their circumstances should be viewed as unique and offered an individualised programme designed to meet their unique needs and aspirations.
9 Professionals must remember that persons with disability are people first. All disability is secondary to this reality.
10 Rehabilitationists should deliver services ethically, always keeping in mind the welfare and autonomy of the client as the primary value. Where conflicts between welfare and autonomy arise, the autonomy of the client should take precedence.

An 11th principle relevant to the NZ context is that of cross-cultural awareness in rehabilitation. The incidence of disability among Polynesian people, for example, appears to be higher than for the European population. Thus, intervention ought to be based, not only on rational, reductionist and analytical science typical of western traditions, but also built on the wholeness and oneness of life, respect for individual human experience, and a reverence for functional capacity, personal independence and dignity; characteristics more often associated with eastern concepts of science (Capra 1982).

3. WAYS OF KNOWING

Knowledge and the way we interpret it as rehabilitationists can be said to rest on four ways of knowing.

1 Empirical science is typified by the natural sciences, is positivist in character and focuses on measurement. Herein are the publicly verifiable facts, descriptions and explanations of the objective world and the theories that arise from conjecture over these observations. The sources of empirical knowledge stem largely from the desire and perceived need to understand the facts and the truth relative to rehabilitation.

2 Personal knowledge is subjective, existential, yet concrete. It is concerned with the kind of knowing that promotes wholeness and integrity in personal encounters; it is concerned with trusting relationships, reflection and self-awareness; focuses on engagement rather than detachment, and denies the manipulative and impersonal. Personal knowledge of oneself is pivotal to rehabilitation in that ours is essentially an interpersonal profession.

3 Ethical knowledge is the understanding of different philosophical positions regarding what is good, what ought to be desired, what is right; the frameworks we use to deal with the complexities of moral judgments and obligations. Ethical knowledge in rehabilitation recognises that it is an action based profession, and involves continual and dynamic choices integral to professional practice. Sources of ethical knowledge stem from a constant and critical appraisal of the norms of practice, and the justification and review of such norms.

4 Esthetic knowledge refers to the abstractions we accumulate through countless experiences in meeting and treating people. It is the recognising and knowing the unique particular situation, rather than generalising from more universal principles; for example, clinical reasoning in a specific case. This abstracted knowledge is the art of practice and is intimately linked to perceptions of the whole person. This is the experience and subsequent expertise that, if more frequently documented, could contribute considerably to the foundations of the art of knowing and clarifying rehabilitation. Esthetic knowledge stems from advanced clinical practice and is more comprehensive than any theoretical sketch can be, since the proficient practitioner compares past whole situations with current whole situations. This art, like science, has its own unique discipline, rigour, detail and structure (Carper, 1978).

The concept of rehabilitation as a body of knowledge interpreted in a unique way is worth examining as rehabilitationists seek to validate their pursuit. This search ought not to be entirely absorbed by identification with reductionist science, important as it is, but also ought to remain open to the powerful healing forces of caring, rehabilitation, counselling, enablement and teaching which are so much a part of effective practice.

Daily, rehabilitationists have to deal with the dilemma of basing action upon adequate quality evidence on the one hand, and inadequate evidence but demand for service on the other. The art of rehabilitation, a legitimate concept, lies with understanding the predicament posed by this dual basis for action, an understanding of the nature of science as well as the chaos of human behaviour.

There is a desperate need to develop methodologies capable of revealing and describing the various aspects of practice. Both descriptive and experimental methods of inquiry help our understanding of the multiple components of effective rehabilitation. Any research strategy that sheds light on what happens when accepted scientific principles are transformed into clinical practice will help clarify the rehabilitation process. Given the present state of knowledge there are risks in judging clinical approaches according to the probity of the available science alone (Bithell, 1999). Knowledge is largely provisional (Popper, 1966).

In rehabilitation there is a need to develop internally consistent forms of inquiry that can deal with quality as well as quantity. A science that can rely on shared subjective experience and observation as well as verifiable measurement.

Recovery often involves coming to terms with one's past, dealing with present perceptions of self and having future hopes and dreams. These are subjective and qualitative notions but are no less important for that.

It is suggested that rehabilitationists have a professional obligation to integrate traditional scientific thinking with a deep understanding of the philosophy, knowledge and practice of human caring (Watson, 1988). Professional development should value wisdom, spirituality and ethics, as well as intellectual and technical skills. Regrettably, today's healing relationships are being modified by fashions in treatment, reimbursement regimes and the threat of complaint (Schon, 1987).

Another challenge for rehabilitationists is to know the difference between sound research on the one hand, and promotion and public relations on the other. For a variety of cultural reasons, a spin is sometimes put on discoveries. There is a changing face to scientific revelation. If science is the process of discovery, what are we measuring in rehabilitation that tells us we have made a discovery and by whose perspectives are those judgements made: clients, professionals, managers, purchasers? When evaluating evidence one must also ask: who funds evidence collection and by which paradigm is that evidence assessed: dualistic or naturalistic?

Evidence is provisional and only as good as the studies done thus far. Health professionals work with far greater uncertainty than do physical scientists such as aircraft engineers. Not only must rehabilitationists deal with the variability of the human condition, but as for any activity dependent upon new knowledge as healthcare is on science, the future is uncertain because new knowledge always changes the rules of the game (Scott, 1995).

More clinically based trials designed by rehabilitationists are needed to ensure the relevance and effectiveness of practice. It is critical to continue the search for links between scientific principles and the results of clinical work. What is more, society benefits from studies that focus on value for money interventions and surveys of unmet community need. Much science as practiced by today's health researchers appears to have limitations when describing the experience of living with illness and disability. Projects that focus on trivial amounts of variation or, on remote characteristics, all in pursuit of scientific respectability, are less helpful to society than practical and insightful studies that impact on people's lives.

Whatever model of inquiry is adopted it should integrate patient values. Failure to observe this simple courtesy recently resulted in the Ministry of Health having to re-think the approach to Home Care Support Services in the lower North Island. The

quest for objective and reproducible outcomes for patients must never be abandoned. Nor should the simple catch-cry from people with disabilities: "Nothing about us, without us".

What About Science and Evidence-Based Practice?

The word 'science' is derived from the Latin, 'to know'. The word 'art', also from the Latin, means 'to do'. Can we not do anything because we don't have all the answers? It would be inhumane to so act. Clearly though, we 'do' much better when we 'know'. Thus, extending the rehabilitation knowledge base is a key objective.

Unfortunately, in the mass media market, the clarity of science is increasingly contaminated by political and economic considerations. Given the competing demands on health and social services, there are choices to be made as to what kind of society we want, considering the possibilities that science now offers.

When engaged in the rigours of disciplined inquiry, it is good advice to stick to the maxims of science which include:

- do everything openly;
- embrace descent;
- publish all the advice;
- acknowledge uncertainty" (Lord May, 2002).

Science must tell it like it is, which may include "I don't know", and leave the ethical questions to society. For example, issues such as rationing should be tackled openly, be based on evidence, look at the health and social costs and benefits, include ethical thinking, be distanced from vested interests and be accountable to the public.

Evidence-based practice is that undertaken by the conscientious practitioner who "integrates individual clinical expertise with the best available external evidence from systematic reviews" (Sacket, 1998).

There is a hierarchy of evidence; with randomised controlled trials (RCT's) the most legitimised type of finding, and personal experience one of the weaker forms of validation.

Whilst adhering to the rigours of objective experimentation and thinking, it is important not to be captured by an institutionalised, 18th century, dualistic, masculine interpretation of science that does not integrate patient values. Nor should one be intimidated by the concerns of resource managers who are paid to focus on resources rather than people. If the goal of clinical education and research is improved practice, then rehabilitation students should be spared being brainwashed by a culture whose roots lie in a particular scientific method that is quickly becoming out-dated by the need to understand the 'chaos' of human behavior. Single, linear cause and effect relationships are only a part of the complexity that constitutes quality healthcare.

RCT's are the gold standard of proof, but if resources to reach that standard are denied, and if RCT design is not up to sorting out the complexities of human behavior, then clinicians have no option but to seek alternative, but objective, means for establishing validity.

Archie Cochrane (1972), is best known for stressing the value of the randomised controlled trial in defining effectiveness and efficiency in healthcare. What is less well publicised is his affirmation of the decent principle of equitable access to effective healthcare. He also made plain in his seminal monograph that although a first challenge is to assess whether particular forms of care are more likely to do good than harm, tough choices will always be needed to decide how resources should be deployed among the various forms of care that are known to have beneficial effects. Significantly, he also emphasised the need to make proper provision for humane, dignified and thus effective care when no effective therapies are available. These issues deserve more attention than they currently receive.

Silagy, writing in the introduction to the 1989 edition of Cochrane's original monograph, says: "The broader reform of healthcare systems to adopt a more evidence-based approach is certainly being pushed along by the existence and work of the Cochrane Collaboration. But the extent to which real changes occur in the way health decisions are made will ultimately reflect the intensely human and personal interactions between the users of healthcare systems and those who provide services".

Silagy argues that the most critical determinant of future directions in healthcare will rest with consumers rather than with health professionals, researchers and their organisations. Silagy suggests that the natural sequel to the Cochrane Collaboration is the empowerment and genuine involvement of informed consumers in healthcare systems development.

Cochrane was an advocate for social justice. He wanted to help people make informed decisions about health. In championing the randomised controlled trial, he was supporting equity and consumer involvement at all stages of the evidence-based process. Cochrane's work epitomises the conjunction between evidence-based practice and patient-centred care. He focuses on medical ethics, outcomes, accountability and, as a sufferer from a respiratory condition himself, values the subjective experiences of illness.

Whilst the randomised controlled trial is the gold standard of experimental design, creative innovation is needed to devise other robust experimental forms of inquiry for which controlled trials are not practicable.

Most health professionals lead a split life. The educated self is based in a mechanistic framework of science where only matter and energy have existence; the external world. Yet, it is clear that there is another side of life; the internal world of connection with family, friends and daily contacts with people who display creativity, emotions and feelings and with whom deep bonds are often formed. This relatedness, and inter-connectedness is more obvious than existing science can describe, at present. We must take common experiences more seriously and not deny that experience because it does not fit a mechanistic paradigm. Rather, those experiences ought to be tested using rigorous forms of inquiry that search out valid, reliable and relevant evidence in order to extend the discovery of the vast mysteries of life.

Ultimately, science and art are tools for the expression of human ends.

N.B.: The Campbell Collaboration does for public policy what Cochrane does for health. Formed in 1999, the international Campbell Collaboration promotes quality

evidence-based public policy making. The demand for more, and better, evidence on which to develop public policy requires new sources of valid, reliable, and relevant evidence. See: http//www.cambell.gse.upenn.edu

4. REHABILITATION, A PEOPLE BUSINESS

Rehabilitation is littered with confusing problems, multiple diagnoses, unpredictable behaviours and pre-existing beliefs, many of which defy technical solution. Schon, (1987), writing on preparing professionals for the demands of practice points out that, compared with the rigours of science, professional issues are messy, indeterminate human situations. They are situations not entirely resolvable by rational and technical approaches. The presenting problems and solutions are often multi-dimensional and defy our existing segmented search for solutions.

Solutions are often financial, environmental, attitudinal and political in nature. A holistic perspective rather than reductionist analysis is called for. We have to operate in clinical situations where there are no right answers or standard procedures. Outstanding practitioners are often not those with more professional knowledge, but those with more wisdom, talent, intuition and artistry, attributes that are not easily quantified and taught. Indeed, traditional research distances itself from understanding such attributes.

The integration and relevance of health and rehabilitation services will grow as concepts of family and community practice, quality of life of the permanently incapacitated, and psychosocial dimensions of illness, take root in institutionalised practice. This is not to exclude biotechnical advances. Learning by doing, getting involved, becoming totally immersed, listening, watching and reflecting are all essential elements of applying research based knowledge to clinical challenges.

Rehabilitation does not always mean the restoration of loss. The term can mean a new start; a creative refurbishment of oneself for a new life and the development of adaptive skills, strategies and attitudes that preserve self-respect, validity and worth. Building a new life around permanent impairment or disfigurement and adjusting to a new self-image, calls for time, personal grit, support, education, achievable goal setting, and pacing with patience. Simply passing on information is not enough. Being informed does not necessarily change behaviour. Changing lifetime habits, perspectives and attitudes require years of rehearsal, evaluation, feedback, explanation and practice. Clients ought to own their personal goals, which should be relevant, interesting and measurable, and to lead to self-efficacy, confidence and mastery. The locus of control of the rehabilitation process is all-important.

If people are to turn their lives around, they need to be understood on their own terms in the first instance.

Inherent in the concept of rehabilitation is a moral ideal that is preservative of the harmony between mind, body and soul; an ideal that enhances human dignity and integrity. Paramount are the ethical principles of autonomy, beneficence, non-maleficence and justice. As Watson (1988), points out, the values involved are those of:

- respect for the wonders and mysteries of life;
- celebration of uniqueness;
- a non-paternalistic style;

- high regard for the individual's subjective and spiritual centre;
- the patient as the agent of change;
- a striving for more self knowledge, self determination and self healing regardless of the presenting condition.
- the intervention is one of mutual discovery and full participation by all parties with the subject at the centre;
- an enabling rather than de-valuing process

To guide and facilitate such a process is a mighty tall order that goes far beyond the application of one's chosen craft. The sheer complexity of disability, individual belief systems and diverse client needs further compounds the demands on practitioners. And yet, consumers expect rehabilitationists to be on their side; to advocate their perspective; to put their interests above all else

Personal Attributes

Rehabilitation as a unique blend of individual, clinical, social and political objectives, calls for personal humanistic qualities of the practitioner. These objectives draw on an internal personal value system capable of understanding and coping with the complex interactions between client and rehabilitationist. Interactions that exhibit attitudes and practices that are exemplary - civilizing in the eyes of society.

Appendix 2 outlines a few perspectives underpinning the delivery of rehabilitation, while Appendix 3 proffers some suggestions of humanistic qualities and attitudes essential to the rehabilitation process and which complement technical competence, objectivity and a sense of social justice. You may like to draw up your own list of personal attributes. These appendices are intended to be illustrative rather than exhaustive.

Clients expect of their rehabilitationist, a manager, communicator, advocate, collaborator and professional. In addition clinical competence in the form of judgement, knowledge and skills are expected along with humanistic values and continuing scholarship (Adapted from Large, 1997).

Beliefs and Feelings, and their Effect on Rehabilitation Outcomes

Rehabilitation is essentially a people business. For most of us, our emotions are the unacknowledged legislators of our personal world. It is well known that the alleviation of suffering can be biomedical, physiological or socio-cultural. However, the effect of belief and feelings on health outcomes remains a confounding variable. How placebos work is still a relative mystery. We all know that feelings, beliefs and values have a powerful effect on patients, as well as researchers.

Damasio (1994), makes the point that the growing knowledge about the physiology of emotion and feelings should make us more aware of the pitfalls of many published studies. He goes on to claim that taking feelings into account does not mean self-absorption and concern, nor does such consideration mean tolerance of lax intellectual standards. Given advances in the neural and behavioural sciences, we should work for increased understanding of feelings in terms of their complex biological, physiological and socio-cultural mechanisms, and the interaction between body, brain, mind and behaviour.

Damasio points out that the mind is rooted in a biologically complex but fragile, finite and unique organism that is fully interactive with the physical and social environment. He concludes by asserting that one of the most indispensable things we can do is to remind ourselves and others, of our complexity, fragility, finiteness, and uniqueness; and treasure these (Damasio, 1994).

5. CONCLUSION

A generation ago, Cochrane saw that Human Rights were an abstraction unless we are denied them. He saw that intellectual propositions die unless they are informed by direct, up-close personal encounters with reality.

Contemporary author Michael Ignatieff, (2000), puts it this way: "We must close the gap between abstract theoretical propositions and practical experience. We must reduce the distance between head and heart; between proposition and disposition; between the abstract and the concrete". Such work is central to who we are as members of a civilized society.

Never has it been more important to recognise the imbalance that is seeping into healthcare practice, depriving us of a sense of meaning because the emphasis is becoming too one-sided and has concentrated on the development of the intellect and economy, to the detriment of the spirit. There are more dimensions to rehabilitation than the purely physical. As rehabilitationists we are called upon to work on the relationship between the uses of science and moral values. We have an obligation to battle against bigotry and insufferable ignorance and prejudice, which are still leading to unspeakable degradation of the human spirit, because of chance intervention of impairment, which we turn into handicap. We are all diminished by failing to challenge the destructive powers of the dark side of the human psyche.

Perhaps rehabilitation as a discipline is not popular because it makes ultimate demands upon rehabilitationists to blend the natural sciences with a deep understanding of self-transcendence, the soul and the meaning of creation. Most often the broken bodies we deal with have intact souls and they cannot "stop the world" and choose to hop on or off. As practitioners we are required to know and accept ourselves to a degree that enables us to connect with other human beings as they quest for wholeness.

“While with an eye made quiet by the power of harmony, and the deep power of joy, we see into the life of things”. (William Wordsworth, "Tintern Abbey".)

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APPENDIX 1

Structural Issues Valued by People with Disabilities

- A place to live:
  - home and community-based support services
  - respite care
  - independent living
  - adapted housing

- Sound education:
  - properly resourced early intervention
  - access to lifelong learning, habilitation, and "revolving-door" access to rehabilitation to accommodate maintenance and life stage development
  - co-ordinated information services

- Something meaningful to do:
  - open employment; job retention
  - training and placement
  - long term supported employment
  - access to creative leisure

- Income that acknowledges the costs of disability

- Health services that encompass personal care, maintenance care and support care; client-centred rehabilitation and needs assessment

- Transportation that is accessible and affordable

- A barrier free environment:
  - removal of obstacles to community integration

- Affordable, hassle free access to adaptive equipment

- Access to the right kind of help:
  - policies that reflect the needs and value of caregivers, whanau, family, voluntary agencies and service providers

- Opportunities for companionship:
  - soul-mate
  - lover
  - loved one
  - confidant
  - support groups
  - consumer advocacy groups

- Participation:
    - full consultative partner in the design, implementation and evaluation of services
    - involvement at strategic level
    - accountability to consumers
    - partner in developing rehabilitation plan

- Safety:
    - feeling personally safe and secure
    - confidence in cultural safety
    - culturally appropriate services that display sensitivity to the needs and preferences of Maori and other groups
    - freedom from exploitation, including demeaning objects of charity

- Having choices in lifestyle

- Image:
    - consideration as equal citizens by State departments, civic authorities and service providers, and by researchers
    - respect as people of worth and with potential who have a positive contribution to make to society, rather than a cost centre

- Having fun

- Anti-discrimination legislation and attitudes

- Consistency in the availability and delivery of services

- Cost effective services that give value for money and are affordable.

- Services that are flexible and responsive to individual circumstances:
    - ability to purchase the best mix of services across the full range of disability support needs

- Services that are minimally intrusive and restrictive, preserve dignity and privacy, and respect the individual's personal knowledge of their own condition

- Access to reliable information on entitlements and eligibility for services

APPENDIX 2

Perspectives underpinning rehabilitationist learning

- Recognition of individual differences and the valuing of the richness that diversity brings to the culture of society
- Concern with help and support when cure is not an option
- Insight and empathy that understands and accepts a person on their own terms
- Creation of a positive, encouraging and affirmative environment
- Focus on quality of life. Choice of lifestyle. Working with, rather than for people, preserving personal identity and functional independence
- Provision of opportunities for personal growth and lifelong learning in the least restrictive setting
- Acknowledging individual life stories and what that individual wants for their future
- Commitment to a philosophy of rehabilitation expertise based on knowledge, reasoned application, craft skill and virtue, where virtue equates to ethical practice, commitment and caring
- Orientation toward client rights, empowerment, autonomy, participation, inclusion, self-efficacy and functional independence
- Obligation to client orientation and advocacy ahead of institutional and funder driven demands
- Focus on functional outcomes and adaptive behaviours and attitudes as appropriate.
- Seeing rehabilitation as an investment in human potential rather than a cost centre
- Realizing that rehabilitation and disability services are necessary social supports that underpin a decent, innovative and entrepreneurial society

APPENDIX 3

Some Attributes Sought in Rehabilitationists

Rehabilitationists who "cut the mustard" with consumers will:

- Embrace a whole person model of health encompassing cultural, physical, psychological, social and spiritual dimensions
- Be committed to the well-being of others
- Value the client as the agent of change
- Be committed to evidence-based practice and contribute thereto
- Welcome continuous professional development, self-assessment, reflection and peer review
- Perfect their craft and understand the contributions to healing made by other crafts
- Have clinical reasoning skills
- Value safe and effective practice
- Be confident working in a team and able to recognise limits of competence
- Have respect for the individual, appreciating diversity of background, life opportunities - or the lack of them, and value cultural safety
- Be ready to close the emotional distance with clients sufficiently to gain insights into their daily experience
- Gain an understanding of the complex ethical issues relating to quality of life and the allocation of resources
- Match the primary consideration for the interests of clients with fairness to the community
- Cultivate a sense of social justice
- Be accessible
- Listen and take time to see the world through the eyes of others - empathise
- Be willing to act as facilitator, coach, motivator, advocate, source of objective information, confidant and therapist
- Be able to re-frame situations and think anew about life's challenges, opportunities and options

- Collaborate with clients in searching for solutions, personal health, well-being, self efficacy and functional independence

- Facilitate engagement with the community as desired

- Recognise the role in rehabilitation of: caregivers, the community, family, whanau and voluntary societies

- Follow the 15th century French adage: "cure sometimes, relieve often and comfort always".