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## *The Physician and Rehabilitation*

The practice of rehabilitation for any physician begins with the belief and basic philosophy that the doctor's responsibility does not end when the acute illness is ended or surgery completed. It ends only when the individual is re-trained to live and work with what he has left. This basic concept of the physician's responsibility can be achieved only if rehabilitation is considered an integral part of medical services.

The physician has always practiced some aspects of rehabilitative therapy though he may not have thought of it as such.

Traditionally, the saving of human life and the relief of suffering were his primary goals. Those individuals disabled by congenital defects, disease, injury, or infirmities of age were accepted as having suffered the expected consequences of their difficulties and were regarded as hopeless.

Today, the fact that life is preserved does not necessarily mean that a good cure has been obtained. The diagnosis and treatment are often so absorbing that there is increasing danger of focusing too much attention on the disease without regard to the person as a whole. The true significance of rehabilitation and its real distinction from preventive and curative treatment rest on the conviction that both lay and medical resources can be used to prevent and treat those disabling complications.

Rehabilitation is every physician's business. Experience has shown that much of all rehabilitative processes can and should be done by the practitioner responsible for the patient's primary medical care. To meet the needs of the more difficult cases, the physician can refer patients to rehabilitation centers where a team approach can be applied, using the special skills of specially trained physicians, physical and occupational therapists, social workers, speech and hearing therapists, nurses, vocational counselors, psychologists, and prosthetics specialists.

These co-professional personnel act as members of evaluating and therapeutic teams. However, one person must be responsible since the patient cannot

effectively be treated by committees. This is the physician's responsibility. Medical guidance is necessary for rehabilitation to have purpose, for, regardless of the type of disability, the responsibility of the physician to his patient cannot end when the acute illness or injury has been cared for. In addition, because of the high prevalence of chronic illnesses and their tendency to be prolonged, the basic elements of early detection and adequate medical care must be complemented by rehabilitation. These services should continue as long as the patient can profit from them.

We must not lose, by neglect of the social and emotional life of the patient, those controls which are not affected by the illness. Custodial institutional care contributes to a deterioration of the patient far beyond what is inherent in the development of the disease itself. It is therefore essential that physically degenerative and socially degenerative processes that diminish the individual's capacity for self-maintenance be prevented, and that we direct efforts at the restoration of the capacity of the individual to maintain himself. We must protect the health of the patient though we cannot cure that part of him which is specifically diseased.

The patient must maintain some goal to his activity. This may mean a return to the status of self-help. It may mean employability, the traditional goal of rehabilitation efforts. Productivity has more than an economic connotation. In any case activity has an important social meaning in terms of the status of the individual.

We must emphasize that we are not dealing solely with physical disability but we are concerned with a person. We must consider and evaluate the patient's physical capacities and consider his vocational, psychological, and social status since these are important factors in his eventual social integration.

Medical care is not complete until the patient has been trained to live and to work with what he has left.

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