CASUISTRY

In the absence of a determinate decision procedure the most common method for making decisions in cases where moral principles conflict is the much maligned method of casuistry, developed so exhaustively by both the Jewish and the Roman Catholic religions, also adopted by Kant, and also (in a way) by the British legal system. Essentially the method, whose objective is the application of accepted moral principles to specific circumstances in which these principles conflict, requires the careful separation of the moral principles relevant to a particular case, comparison with clearer or "paradigm" cases determined by each of the principles, and an attempt to settle the difficult case as coherently as possible with the existing pattern. Though the methods of casuistry have far more value than the common pejorative use of the term indicates, they are, none the less, radically limited so far as determining or questioning what those basic principles and their relative importance should be.

OTHERS

One further approach of pluralist deontological moral philosophers to the resolution of conflicting moral principles is to rank the principles in order of priority. For example, John Rawls, to whose theory I shall return when I discuss the principle of justice, argues for a "lexical ordering" of his two main principles, an order "which

requires us to satisfy the first principle in the ordering before we can move on to the second"⁶

The questions whether a determinate method for resolving moral conflict is attainable in principle and has been attained are among the most hotly disputed in moral philosophy. In the next article I shall consider a cluster of theories that offer an affirmative answer to both these questions.

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Needs and Opportunities in Rehabilitation

The time is now: education and organisation of services

DAPHNE GLOAG

At one rehabilitation centre I visited a group of medical students, interested and concerned young people, were having their introduction to rehabilitation—the only half day devoted to the subject in the entire course. Few medical schools do more than this formally. The subject is assumed also to be part of general clinical teaching, but may not amount to much. But while many workers are urging more initial teaching of rehabilitation and subsequent training, the concept and practice of rehabilitation are coming in for increasing criticism from disabled people. Finkelstein, for example, has argued that rehabilitation should not exist as a separate medical discipline: to start with, it should be a normal part of good medical practice; but beyond this, for the more social issues, medicine is a bad base from which to approach a disabled person's problems.¹

I return later to these arguments, but the first point—that rehabilitation should be an integral part of good medicine in general—would be widely accepted, though it is usefully treated also as a specialist subject. One of the strongest convictions I have formed while working on this series is that rehabilitation needs to be a philosophy permeating many branches of medicine: a habit of looking for the strengths and weaknesses in a person's functioning and helping him to develop the best possible level of functioning—

physically, mentally, and socially—and to work out the best possible way of life, assisted by whatever high powered and simple aids are needed and acceptable. Many of the actions that flow from this are clearly outside the scope of medical and even paramedical services; but within ordinary medical practice there should be not only the vision of how things might be better for an individual patient but also some of the activities (or initiation or at least knowledge of activities) that are needed to make them so. For visions to become real motivation of patients and relatives and of other workers is central. In theory, with this kind of orientation, many powerful changes could happen here and now, without waiting for the millennium of increased resources—much though these are needed too. Staff who are rehabilitation minded will develop different approaches to patients and families and will devise often informal ways of getting things done where full fledged facilities are not available. But this will happen widely only when rehabilitation, as an attitude, a strategy, and a commitment—wider than physical medicine—is part of the philosophy of medical teaching right from the start.

Education and training

UNDERGRADUATE TEACHING

"No one ever suggested to us," said a young doctor, "that all those patients with strokes filling the wards might have something

done for them." Undergraduate teaching in the United Kingdom, according to a Council of Europe report, is said to deal with the philosophy and process of rehabilitation, both in theory and in practice, with compulsory examination in the subject.² This may be the ideal but, it has been said to me, it is not the reality—the rehabilitation content in the various subjects is submerged in acute medicine with its emphasis on diagnosis and treatment.

This report urges interdisciplinary teaching, seeing the "compartmentalised" structure of much medical teaching as an obstacle to effective teaching of rehabilitation.² But Blaxter makes several recommendations that do not depend on any restructuring of medical education.³ Arguing for rehabilitation both as a specialised subject and also as an integral part of other specialties, she emphasises that it should be treated "in a much more scientific and sophisticated way" within specialties, but also giving regard to sickness and disability "as social as well as clinical facts."

The University of Southampton Medical School is now trying a different focus for its two and a half days' formal introduction to the subject. Instead of just looking at what goes on in a rehabilitation department or centre, students are taught the difference between a routine clinical examination and an examination including assessment of functional abilities. They also learn just how sophisticated are the assessment and other skills of remedial therapists.

Essential themes for all doctors' training in rehabilitation that should be woven into medical teaching, it was said to me, include taking a "social" history (covering things like relationships, house layout, job security); considering whether there are symptoms that could be remedied, and how best to tackle handicaps and aid independence; asking, if independence goes, who is to give care and where; and asking, if the doctor cannot help, who could (fellow sufferers, priest, friends perhaps). Danger spots not emphasised in textbooks should also, someone said, come into the teaching of rehabilitation. One is discharging patients from hospital, which remarkably may still be done without information for patient or relatives or any real preparation. One man recently was discharged to his caravan home and his uncomprehending family three days after a stroke that had left him dysphasic, only to be admitted later, overwhelmed by the intolerable problems, to a psychiatric ward. Also in the danger category are "milestones" (especially in a progressive condition like multiple sclerosis) such as the start of difficulty with walking, the start of incontinence, and having to give up a job; here, it was said to me, future doctors need to be taught to review priorities with patient and spouse at the earliest moment, in the hope of preventing needless trouble and strife.

Too many professionals are isolated from the new movement among younger disabled people, said Finkelstein in a paper to the Medical Disability Society (London, December 1984): solving problems for patients and clients makes them passive and dehumanised, and they want a joint approach, professionals working *with* them as teachers rather than therapists. This then is a further change of orientation needed in medical teaching.

GENERAL PRACTITIONER TRAINING AND CONTINUING EDUCATION

Rehabilitation, it might be supposed, would be an important aspect of training for primary care. The general practitioner is the only doctor many people with disabilities will be under. For others he is well placed to be a "key worker" identifying needs and bringing everything together, and someone the disabled person can turn to—for which he does not need to know everything but must know in general terms what is possible and available, and how to guide the patient in the right direction for services and information. Knowing about the availability of aids tends to be a particular gap and, someone said, GPs often are not familiar with community occupational therapy services. So training should have this kind of focus, and a focus on psychological aspects of disability and prolonged or incurable illness. Developing "the imagination, sensitivity, and awareness necessary to recognise and assess problems"⁴ is clearly essential in primary care. Strangely, rehabilitation is not explicitly mentioned in the requirements for membership of the Royal College of General Practitioners.

An environment that "can guarantee accessibility both physical and psychological" is called for in a Council of Europe document on policy for rehabilitation.²² This arts centre, in a Victorian former town hall, has been made accessible to wheelchair users by the new ramp that is partly visible in the photograph, which permits them to use the main entrance like everyone else; inside, a lift to the upstairs theatre has been installed. "I want to make the centre available to everyone," said the director.²³ For many new public buildings access provisions are to be incorporated into the revised 1976 Building Regulations, which come into force this year; the requirements will be extended later, and the Access Committee for England will oversee the changes. (Photograph by Anita Corbin, reproduced by courtesy of the *Designers' Journal*.²³)

In the Council of Europe document, in reply to the question about the "permanent training" of doctors, it is said that trainees having vocational training in general practice in Britain "have the opportunity of acquiring first hand experience in the application of rehabilitation techniques" and that GPs have opportunities for attending regional or national courses and symposia on rehabilitation medicine.² But trainees depend for their experience on their trainers' interest in the subject, and GPs may not have time to attend such courses.

For trainees visits or attachments to occupational therapy departments have been proposed.¹ I have heard of GP vocational training schemes organising sessions to introduce or demonstrate rehabilitation principles in particular conditions. In Harrow patients with multiple sclerosis and with stroke, and also their spouses, were introduced to trainees, together with therapists, for experience in the "holistic" approach.

A postgraduate adviser in general practice said to me that to label a course or meeting "rehabilitation" was to give it the kiss of death; the subject was best dealt with in the context of specific clinical topics. Various approaches have been suggested.¹ The new Medical Disability Society will be attempting to stimulate interest, and meetings, in the localities of its members. The Open University has a continuing education pack of materials on rehabilitation for professional workers; they are designed for individuals or groups and require about 50 hours' study.

HIGHER TRAINING

Nearly 30 years ago the Piercy report recommended that every consultant should supervise the rehabilitation of his own patients,⁶ a

recommendation repeated by the Tunbridge report in 1972.⁷ This is still the official view. But the Joint Committee on Higher Medical Training of the Royal Colleges of Physicians requires knowledge of rehabilitation for specialisation only in geriatric and occupational medicine and rheumatology apart from rehabilitation medicine itself—not even neurology.⁸ Rehabilitation is not included as a requirement for any surgical specialty, even orthopaedics.⁹ Yet the need for rehabilitation after amputation, mastectomy, or an ileostomy operation is obvious; indeed, many major operations, especially for cancer, may call for some forms of rehabilitation. Though not providing them personally, the surgeon responsible should surely be required to have had some training in rehabilitation if he is to ensure that something appropriate is available.

There are only three senior registrar posts giving accreditable training in rehabilitation medicine and 18 others in rheumatology and rehabilitation; no other combinations exist. Some rehabilitation consultants believe that combined training is badly needed, especially with neurology or general medicine as the major specialty. Many doctors going into general medicine are said to want this but cannot get the right higher training. A few consultant posts are, however, being planned on this basis, with designated sessions in rehabilitation. In neurology with its traditionally diagnostic orientation and the great workload in Britain that prevents consultants from playing much part in rehabilitation, there is a particular need for neurologists “with an interest in rehabilitation.”

In all specialties, it has been proposed, registrars should have training in rehabilitation medicine, to “create interest and understanding and to maintain recruitment to senior registrar posts.”¹⁴

Organisation and planning of rehabilitation services

Thus three kinds of consultants with training in rehabilitation may be envisaged: many who have rehabilitation integrated into the regular work, whatever the discipline; some who have a few or perhaps half their sessions designated for it, and from a position of equality will, as someone put it, “nudge, shame, or cajole” the other consultants in their main specialty—neurology, cardiology, respiratory medicine, for example—into taking rehabilitation seriously; and a smaller number who have overall responsibility for rehabilitation services in their district or larger area, whether whole or part time.

But if rehabilitation should be integrated with the ordinary practice of the various specialties why should rehabilitation medicine be a separate specialty? One reason is that the integration has not yet got very far, so separate specialists are often needed. They would in any case presumably have to give advice on facilities and so on to those providing services within the other specialties.⁴ Secondly, there is the argument of time and efficiency: in organising and coordinating services (in conjunction with local authorities and voluntary agencies) and fighting for resources on behalf of therapists and other workers “for the health and vivacity of rehabilitation services,” as someone put it, there comes a point where it would not be practicable or cost effective for each consultant to make his own arrangements. Some argue that this coordinator need not or should not be a doctor, but others believe strongly that he should (though in the planning and implementation of services it is important that disabled people themselves should have a responsible part, and have the non-medical aspects separated from the medical umbrella^{9(a)(b)}). Furthermore, the wider development and strategic planning of services in a region may in practice call for rehabilitation specialists.⁴ Thirdly, some rehabilitation problems—such as severe brain damage—are so complex that they cannot be dealt with adequately by local services and special centres are needed for “tertiary” referral.¹¹ Finally, specialists in rehabilitation are important educationally: they have a “catalytic role” in stimulating interest and spreading knowledge and skills, not least among primary care teams.⁴

In guidelines for planning in their own region Wood and Holt recommended that consultants in rehabilitation should be based on subregions with populations of usually around 1 million, with two “whole time equivalent” consultants for each.⁴ A more common

Bridging gaps

The Wessex Rehabilitation Association, based on Odstock Hospital, Salisbury, is an interesting example of a charitable body supplementing the work and funds of statutory services and being largely self financing. Established in 1962 to form a bridge between hospitals and the world of work, it has grown from a core of industrial companies and of doctors, aiming to help people who become disabled physically or mentally to return to open employment as quickly as possible. It also promotes industrial therapy and sheltered workshops, and encourages member firms to provide contract work and second hand machinery. But the association is now wider in scope, more analogous to RADAR and MIND on a local scale, with various projects concerned with fund raising and with research—including the provision of an all weather helicopter pad for the spinal injury centre at Odstock Hospital.

view, I gather, is that consultants should be district based, with one and a half or more whole time equivalent posts in each district. The argument that each district needs its own consultants holding the “corner” in rehabilitation seems a strong one. But in practice, at present, the resources of a district will often not permit this. And if only one district in a locality could afford rehabilitation consultants these would come to serve neighbouring districts too. So some grouping of districts, suggested one expert, may often be more practicable.

The arrangement favoured by Wood and Holt and by many others is spreading rehabilitation sessions among several consultants working in other disciplines as well. One of the advantages of part time rehabilitation consultants is status. The messages of rehabilitation are more likely, it is said, to be heeded if they come from acknowledged experts in other relevant specialties. Nevertheless, said someone who does believe in the benefits of part time rehabilitation consultants practising another specialty, in fact this may be tricky: it may be taken to imply, perhaps with reason, that other consultants in the specialties concerned are not rehabilitating their own patients and thus are not practising good medicine.

Rehabilitation centres¹² and specialised units have developed as a result of the interest of individuals rather than of regional planning and many parts of the UK have none. Worse still, manpower in medical and other services relevant to rehabilitation differs widely among different regions: access to good medical care may depend on where one lives, and areas with apparently the most need in terms of particular services are the worst off for manpower.¹³ In rheumatology, for example, there are over seven times as many consultants and senior registrars in relation to population in the North East Thames region as in Yorkshire. In rheumatology again, some districts have minimal specialist help or none at all.¹⁴ Thus an urgent task for planning is to work out how some of the inequalities could be reduced.

Geographical inequalities apply also to physiotherapy and occupational therapy.¹³ In all the remedial therapies, and other professions relevant to rehabilitation, the demands on often meagre services are massive; but the hard data needed for proper planning are in short supply. Joint planning on the part of health and social services, and other agencies, is essential for making the best use of resources.

Information

Deliberations about services often draw on the findings of Harris's major survey, published in 1971.¹⁵ A new national survey is being carried out this year by the Office of Population Censuses and Surveys to provide up to date information on the prevalence of disabilities of different kinds and severities, on the financial and

social consequences to the sufferers, and on the uptake of social security benefits and of health and social services. Some experts who might usefully have contributed to the questionnaires and the plan of the survey, however, were consulted too late to have much influence.

Local surveys and registers are in any case needed for effective planning, and for ensuring that disabled people are not missing out on any form of help they might be having. A good example is the Southampton survey and register.¹⁶ Many people were not getting all the help they needed according to a study by Knight and Warren, who emphasised the importance of both effective case finding and continuing surveillance.¹⁷

Not only should services "discover" consumers but consumers need to discover services, as Brechin and Liddiard point out, giving illustrations of "the complexities of service structures within which people struggle to offer, and others struggle to receive, a co-ordinated and rational service."¹⁸ But in the absence of a knowledgeable adviser a person needs to know something before he can begin to discover what is available¹⁸: "to those that have shall more be given." So complex is the network of benefits and of statutory and voluntary services and sources of help¹⁹ that any one worker may well not have all the answers but should know how to get them or help the client to do so. Good information about aids is particularly important (see 12 January, pp 134-5; 19 January, p 220); but ironically people with disabilities are often losers in the age of technology. One result of the movement towards participation and self help among disabled people is the national network of telephone information and advice services called DIAL²⁰ (details from 117 High Street, Clay Cross, Chesterfield S45 9DZ).

Conclusion

At the end of this series much remains unsaid and many subjects untouched, but two lines of thought continue to niggle. One concerns research: for example, which methods of management are most effective and which should be scrapped in different types of case, and what new methods might be just round the corner? So much is not backed by good evidence, answers are partial, meagre resources could be used to better effect if guided by good investigations. Research activities are indeed increasing and will, it is thought, aid and be aided by the growth of rehabilitation as a discipline. Diploma and degree courses in rehabilitation for therapists and others, at Southampton and a few other places, should spread. But research may be expensive. I return to Miller's discussion of the management of neuropsychological effects of brain damage. Much scientific evaluation of methods can be worked in with ordinary clinical practice, given staff with the interest and knowledge. In the early development of an area of work there are few certainties but techniques of possible value can be developed and tried out here and now—perhaps with single case studies), with rigorous testing later—provided that sloppy methods of evaluation are avoided at all stages.²¹ A worrying problem is the dilemma of either carrying on with an approach of unproved benefit or of doing nothing for an individual, or less than might be done.

A second recurring theme that I have touched on before is the great chasm between what is available here and now (and I have come across many remarkable services and projects, statutory and voluntary, large and small) and what is actually received by an individual. Partly this is due to poverty of resources and overstretched staff, partly to sheer inefficiency or ignorance. Better education and training, better organisation of services, and better information can all make a big difference within the confines of present resources. So can the imaginative use of all sorts of help, relevant and sensitive to the individual, however informal. But people often expect so little. Patients, relatives, doctors, and other workers need to believe that soldiering on making the best of a bad job is not good enough. To quote Ezra Pound, "Here error is all in the not done."

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If a woman with Raynaud's disease starts taking the contraceptive pill and her symptoms are not aggravated in any way, is it safe to continue taking the pill?

In the study of the Royal College of General Practitioners the incidence of Raynaud's syndrome was three times greater in users of the combined pill as compared with controls, and the difference was statistically significant.¹ It was concluded that oral contraceptives may have an action on the walls of small vessels, perhaps enhancing neurovascular sensitivity. Hence if the patient's symptoms had begun for the first time when taking oral contraceptive, or appeared to be aggravated, an alternative method should be suggested. Since this patient's symptoms seem unrelated to treatment, however, she could continue taking a modern low oestrogen (less than 50 µg) combined pill. It would be important to establish that the condition was not Raynaud's syndrome secondary to an underlying disorder. The differential diagnosis is described in standard textbooks.² If, for example, her symptoms were related to occlusive arterial disease pills containing oestrogen should be avoided. The same would apply in the rare severe cases of primary Raynaud's disease where there are early ischaemic changes in the skin of the digits and nails. This patient should be warned to stop taking the pill were such changes to occur, to protect her hands from the cold and, if relevant, to stop smoking.—JOHN GUILLEBAUD, senior lecturer in gynaecology, London.

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