
Editorial

The goals of rehabilitation for older people

'We are trying to improve this patient's quality of life' is the often stated goal of much therapeutic effort made for elderly people; but what is meant by this medical shorthand? Is the intention to improve autonomy or improve ability in activities of daily living? To reduce spasticity and improve standing balance or reduce impaired mood and achieve better acceptance of disability? Is it simply to get the patient back home? All of these are reasonable therapeutic goals and all may be justified under the umbrella of 'improving quality of life', but the imprecision of this term is not very helpful, either clinically or for evaluating patient care.

Health-related quality of life has been widely promoted as a means of obtaining a patient perspective on the benefits or failures of treatment as distinct from professional views. New scales such as the SF-36^{1,2} might prove to be useful measures of outcome for rehabilitation. However, they share the problem of imprecise definition and insufficient reliability for clinical purposes.³ A far more useful model for rehabilitation is the World Health Organization classification of impairments, disabilities and handicaps⁴ which has not received the clinical attention it deserves. Attempts have been made to convert the disability classification into a measurement instrument and a set of weighted scores on each of 10 disability dimensions has been produced and used in a national survey of disability.⁵ Handicap (the disadvantage associated with impairment and disability) has proved a more difficult concept to work with, but a postal survey scale, the London Handi-

cap Scale, is now available and has been widely used with stroke patients as an outcome measure.⁶

The evaluation of specific therapies is complex and will not be done satisfactorily by simply examining a patient's quality of life or handicap score, assuming that treatments which improve impairments will also have a direct and predictable effect on disability and handicap. This has been referred to as the 'fallacy of misplaced holism'.⁷ In evaluating specific rehabilitation techniques, such as procedures for increasing muscle strength or joint flexibility, it is obviously sensible to use the relevant measures of impairment. When evaluating a rehabilitation 'service' including these specific techniques, it is essential that the whole box of tricks and techniques produces real benefits for the patient – namely reductions in disability and in handicap. If this is not achieved, the service cannot be considered successful. This is increasingly being recognized in acute medicine⁸ where the romance with high technology measures of impairment is becoming jaded by a realization that holism in *treatment* does matter.

Rehabilitation comprises two major components: 'reablement' and 'resettlement'.⁹ However, the criteria for successful rehabilitation are often limited to independence in a limited range of basic activities of daily living. Reablement is most obviously concerned with reducing disability and the appropriate outcomes must be disability measures. 'Resettlement' is a more complex goal and implies the restoration of people to their own, or sometimes a new, environment. This goal is more concerned with reducing the disadvantage

associated with disability and measures of handicap are the most appropriate indicators of success or failure. Too often, the goal of resettlement is simply translated into getting a patient home, with little serious consideration of how the patient will live. Length of stay then becomes the only relevant indicator.

A recent Royal College of Physicians survey of geriatricians in the UK demonstrated that for the majority, the goals of geriatric medicine are limited to concerns about treating acute illness and reducing disability,¹⁰ with little interest in reducing handicap. Since elderly people constitute the largest group who require rehabilitation and geriatricians control access to the relevant resources, this limited view of the scope of geriatric medicine is extremely worrying and unlikely to change, given the very small number of consultants and trainees with adequate training in rehabilitation. The lack of enthusiasm for reducing handicap and improving the process of resettlement is a source of much conflict between relatives and professionals, and between doctors and other members of the rehabilitation team.

Much of this conflict can be understood by examining the ethical frameworks within which the different players operate. In most cases, family, nurses and therapists want to do the very best for the individual patient, almost regardless of cost. Doctors, while often claiming to share this ethical imperative, frequently attempt to balance the good to the individual with the greater good to society: a utilitarian attempt to use resources to achieve the greatest good for the greatest number. Hence, doctors tend to feel the pressure of the great weight of patients needing a hospital bed more keenly than their nonmedical colleagues.

Virtually all the measures of outcome (survival being the exception) are based on this utilitarian view of health care. They attempt to give an objective index of the 'health gain' or quality-adjusted years of life obtained for a given investment. This approach assumes that such information will have value because it makes explicit the relationship between inputs and outputs. Any rational person will choose the inputs associated with the best outputs – the biggest bang for your buck.

Perhaps some of the resistance to using standardized measures of disability recommended by the Royal College of Physicians¹¹ is a reaction

against ideas which run counter to usual clinical practices and do not have a demonstrable impact on the process of care or patient outcomes.¹² It is important to examine the reasons behind this apparent refusal to make 'before and after' measurements of disability: such techniques are crucial to evaluating the goals of rehabilitation.

Disability scales currently used have a major disadvantage in that they are limited by a very low ceiling. The most difficult activity in the Barthel scale, taking a bath, does not necessarily represent the pinnacle of human achievement, even for a hemiplegic person. Extended, or instrumental, activities of daily living scales have been produced which consider a wider and more exciting range of activities but many of these are gender and social class biased which can present problems if data are aggregated and used to compare services.

The sensitivity of most of these scales is inadequate to detect the size of clinical changes that would satisfy most therapists and their patients, and their reproducibility is too poor to distinguish random variation from real treatment effects.¹³ Further development even of simple disability and mood scales is clearly a high priority.

Patients' views of rehabilitation have been neglected. Studies in physiotherapy suggest that the process and symbolic value of rehabilitation is as important as any effects on recovery.¹⁴ The nonspecific aspects of rehabilitation – hope, touching, acceptance, exercise – have benefits which are certainly valued by patients, but they might not lead to improvements in conventional outcomes.

Goal attainment scaling has recently been introduced as the best compromise that can be achieved between utilitarian and clinical ethical standpoints.¹⁵ It models routine clinical practice in formulating problem lists, defining goals and priorities in conjunction with the patient, carer and rehabilitation team. The proportion of goals attained in a given time is then used as an index of success for the individual and can also be aggregated to examine the performance of a unit over time. This approach deserves much more attention as it is likely to overcome much of the clinical antagonism to standardized measures that appear irrelevant to the goals of treatment.

The whole concept of outcomes presents real problems for rehabilitation because of the length of the rehabilitation process and the multiplicity

of specific and nonspecific therapies used. Outcomes tend to be most useful in areas of medical care where the time interval between treatment and outcome is short: intensive care, surgery, acute medical treatments. In circumstances where the interval is long, such as in cancer chemotherapy trials, the solution is to use large numbers of patients and unambiguous outcomes (i.e. survival, recurrence or cure) that are unlikely to be influenced by other nontherapeutic factors. In rehabilitation, the use of disability or handicap as outcomes is difficult for the same reasons that the practice of medicine in old age is challenging: multiple pathology, interactions between aging and disease, social adversity, inherent agism among patients and professionals. In general, where care is given and received over lengthy periods of time (e.g. palliative care, psychiatry, rheumatology, learning difficulties, neurology) the point at issue is not survival, cure or recurrence, but is whether patients' lives (and deaths) accord with their wishes. If we are to assess the overall impact of such care, we will need to examine a person's entire 'care career', rather than measure an 'outcome' at an arbitrary time. This is the real challenge of measurement in rehabilitation.

Shah Ebrahim, Professor of Clinical Epidemiology, Royal Free Hospital School of Medicine, London, UK.

References

- 1 Ware JE. Measuring patients' views: the optimum outcome measure. *Br Med J* 1993; **306**: 1429–30.
- 2 Jenkinson C, Coulter A, Wright L. Short form 36 (SF36) health survey questionnaire: normative data for adults of working age. *Br Med J* 1993; **306**: 1437–40.
- 3 Gompertz P, Harwood R, Ebrahim S, Dickinson E. Validating the SF-36. *Br Med J* 1992; **305**: 645–46.
- 4 World Health Organization. *International classification of impairments, disabilities, and handicaps*. Geneva: WHO, 1980.
- 5 Martin J, Meltzer H, Elliot D. *The prevalence of disability among adults*. Office of Population, Censuses & Surveys. London: HMSO, 1988.
- 6 Harwood RH, Gompertz P, Ebrahim S. Handicap after stroke. *J Neurol Neurosurg Psychiatry* 1994 (in press).
- 7 Tallis R. Rehabilitation of the elderly in the 21st century. *J R Coll Physicians Lond* 1992; **26**: 13–22.
- 8 Cowley AJ, Fullwood LJ, Muller AF, Stainer K, Skene AM, Hampton JR. Exercise capacity in heart failure: is cardiac output important after all? *Lancet* 1991; **337**: 771–73.
- 9 Ebrahim S. Rehabilitation. In: Brocklehurst JC, Tallis RC, Fillit HM eds. *Textbook of geriatric medicine and gerontology*, fourth edition. London: Churchill Livingstone, 1992: 1038–54.
- 10 Dickinson E. *The goals of geriatric medicine*. Abstract presented at the Society for Social Medicine, annual meeting, Cambridge, September 1993.
- 11 Dunn RB, Lewis PA. Compliance with standardised assessment scales for elderly people among consultant geriatricians in Wessex. *Br Med J* 1993; **307**: 606.
- 12 Rubenstein LV, Calkins DR, Young RT *et al*. Improving patient function: a randomized trial of functional disability screening. *Ann Intern Med* 1989; **111**: 836–42.
- 13 Gompertz P, Pound P, Ebrahim S. The reliability of stroke outcome measures. *Clin Rehabil* 1993; **7**: 290–96.
- 14 Pound P, Gompertz P, Ebrahim S. Patients' satisfaction with stroke services. *Clin Rehabil* 1994; **8**: 7–17.
- 15 Malec JF, Smigielski JS, De Pompolo RW. Goal attainment scaling and outcome measurement in post-acute brain injury rehabilitation. *Arch Phys Med Rehabil* 1991; **72**: 138–41.

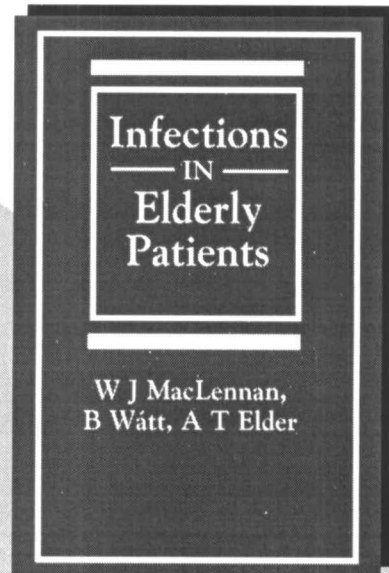
CARE OF THE ELDERLY

New from Edward Arnold

Infections in Elderly Patients

- offers a comprehensive overview of the types of infections affecting elderly patients
- emphasises immunological function, antimicrobial agents and prevention and control
- covers a subject which until now has been split into a range of texts
- authorship of two geriatricians, a microbiologist and a virologist ensures an integrated approach to the subject

April 1994 • Hb • 176pp • 0 340 55933 0 • £24.99



Confusional States in Older People

CONFUSIONAL
STATES IN
OLDER PEOPLE

Eleanor
Jane Byrne

Confusional States in Older People

- presents a broad overview of confusional states
- explores the relationship of confusional states to different clinical settings
- combines practical clinical advice with the latest research findings

June 1994 • Pb • c.112pp • 0 340 56298 6 • c.£14.99

Edward Arnold

A member of the Hodder Headline Group

Order from your local bookshop or contact: Sabine Bohnacker, Edward Arnold, Marketing Department, 338 Euston Road, London NW1 3BH, UK. Tel: +44 (0)71 873 6355 Fax: +44 (0)71 873 6325