

Rehabilitation Abroad - Why?

BACKGROUND

Rehab Without Walls started in 1994. We manage severely brain injured patients, mostly in the community, using case managers who set up and implement individual treatment programmes. Our case managers come from different backgrounds including social work, therapy, and nursing. Our referrals come largely from lawyers or insurers, as most of our 85 patients are involved in compensation claims.

We recently referred one patient (KL) to a rehabilitation unit in Germany for post acute rehabilitation, after acute early rehabilitation in an English rehabilitation unit. KL's English rehabilitation consultant was a great support. KL is the second patient we have sent to a foreign unit. KL had achieved his early rehabilitation goals, and we agreed with his rehabilitation consultant that further rehabilitation was needed. We carried out an options appraisal looking at British units in the statutory and independent sector. We could not identify any that both met KL's needs, and he was happy to attend. We proposed a German unit that we knew well, and matters developed from there.

I have been heavily involved in rehabilitation in Europe, through my involvement in the European Brain Injury Society (EBIS), which allowed me to interact with rehabilitation staff from a large number of European countries, and to visit their units. I rapidly identified some units to which I would very much like to send my patients, because of the presence of very well trained, highly motivated and enthusiastic staff, who worked as part of a team in a unit that was bright, friendly and clean.

ADVANTAGES OF REFERRING ABROAD

We find three advantages: rehabilitation quality; "look and feel"; and rehabilitation philosophy.

Rehabilitation Quality

High quality neurorehabilitation is available in Britain. However, the quality and quantity may be driven by the exigencies of local policies and budgets. Key staff come and go, and a unit that last month was excellent, next month may be rather mediocre (this point applies to any unit). As we work in the independent sector, we use whatever resources are necessary, including statutory sector, the independent and charitable sector and unusual quirky individual resources. From time to time, we find difficulty in interacting with staff in the statutory services, who see us as "private", and motivated only by financial matters, particularly personal greed.

In British rehabilitation units there is usually a rehabilitation team, but this may exist in name only, comprising individuals with their own professional agendas, who meet briefly (perhaps once a week), and then disappear to work independently with the patient. Instead of a dynamic team in which everyone pulls together, we see a "parallel tube" model of service. There is an occupational therapy "tube", a medical "tube" and so on. They each are concerned about their individual specialist matters, and while individual clinicians may be skilled, they do not share skills with each other, or to any major degree support each other. We also worry about the extent to which a rehabilitation team constructs individual goals which are specific to our patient, or simply slots the patient into a generic rehabilitation system which may, or may not, meet the patient's needs.

When I consider the specifics of the service in Germany which we used (Kliniken Schmieder), the issue of quality

becomes starkly apparent. Kliniken Schmieder was set up over 50 years ago by Dr Schmieder, and has been owned by the same family ever since. The current director is the daughter of the founder, and she jealously guards the quality and reputation of the service. The service has 827 rehabilitation beds spread over 5 units, 3 of which specialise in neurorehabilitation at varying stages after injury, and two of these have full neurodiagnostic facilities including an MRI with consultant neuroradiologist, and neurophysiology laboratory. There are very strong links with local medical schools and related higher education facilities. For our patient we had the opportunity of a single room, double room, or apartment – we chose the latter. Our patient's timetable was full and detailed, and contained no "time fillers" such as 2 hours of morning "personal hygiene". Our patient had timetabled therapy and treatment between 9.00am and 5.00pm, which included formal sessions of rest/sleep. The nature and intensity of treatment components changed as our patient's clinical status changed.

As a general matter, a comparison of British rehabilitation units with German units is very revealing. A unit of hundreds of beds, with full neurodiagnostic facilities is by no means unusual in Germany, where the patient essentially has a "one stop shop", so that all needed services are available on site. This is in marked contrast to the British scene of small (often very small) units, which may have very limited specialist medical, technical, and nursing support immediately available.

The Fabric of the Unit

It is a cliché to talk about the rundown state of many NHS facilities, and this paper is not an exercise in NHS bashing. Our patient and his family were staggered at the difference in presentation between a (good clinically) English rehabilitation unit, and the German unit to which we made the referral. The German unit was bright, light, airy and above all, clean. The cleaners were evident, they appeared to be everywhere, and were highly diligent, committed to doing a good job.

Rehabilitation Philosophy

This aspect is important, and usually ignored in British rehabilitation. This is the existential issue of recovering from any trauma, particularly a brain trauma. The idea that a patient might have spiritual needs, and facing existential problems (who am I now?, what can I do? what will I be able to do?), is alien to many neurorehabilitation services in Great Britain. In the German unit, this aspect was taken for granted and built into the rehabilitation programme.

DISADVANTAGES

There are three areas of potential disadvantage: practical issues; cost; and English language and related matters.

Practical Issues

The most difficult practical issues were more peripheral issues such as, for example, liaising with local taxi firms. We drew on all our resources here, including two staff members who were German speaking, other colleagues in Germany as and when necessary, and of course, staff in the German rehabilitation unit.

Other practical matters, such as access to airports, wheelchair access (our patient at that time was in a wheelchair), and liaison with the low cost airline that we chose, concerned us. With sufficient notice given to airport



Dr Neil Brooks trained as a Clinical Psychologist, and with Cathy Johnson, set up Rehab Without Walls in 1994. They use case managers to manage people with severe brain injury in their community, using a "whatever it takes" model, mixing and matching statutory and independent resources as needed.

authorities and the airline, and two reminder phone calls to each, there were no problems at either end.

Cost

The main costs involved are the treatment and hotel costs at the rehabilitation unit, transportation, and the case manager's time. Rehabilitation costs are difficult to compare with those in England, because of the problem of comparing like with like, and because Kliniken Schmieder has a sliding scale depending upon severity of brain injury, and nature of accommodation. The costs for Kliniken Schmieder are between around £2200 and £3400 per week, with all services and treatment included. In England, costs are between around £1100 and £3400 per week, depending upon the nature of the service. The cheaper services are typically offering care/support rather than active rehabilitation. The costs must be considered in the context of the "one stop shop" approach to service delivery discussed above, and we considered that the costs were extremely low for the high quality of input which our client received. Transportation costs were minimised by using a low cost airline, and a taxi firm which had a relationship with the rehabilitation unit, and which therefore gave us a discount. Case management time was no more than would have been the case had a UK unit been used.

English

All of the rehabilitation staff in the German unit spoke English to some degree, so day to day communication was not an issue. Ancillary staff such as cleaners mostly did not speak English, but they were so cheerful and friendly that our client rapidly learned basic meet and greet German phrases from them. The real issues about English came in documentation, and in leisure time. We had agreed before rehabilitation began that the initial assessment and treatment plan would be translated into English. This did not immediately happen, and this was a source of (minor) frustration that was solved readily, by giving the documentation to one of our German speaking staff, and ask-

ing for a rapid translation! English may have become a problem had we wanted therapy for subtle language problems, or had we needed more psychologically driven therapy, such as psychotherapy. The major issue about English, and access to English, came in the evenings and weekends. We had arranged with the clinic that at least one English language satellite television station would be available, but this arrangement never materialised. In the event, our client was not particularly concerned about this lack, as he rapidly discovered a bar in the local village which was the haunt of the local "bikers". Our client had been a biker and rapidly became something of a local celebrity, looked after, indeed protected, by the community in the local bar. He learned more German that way, but I am not sure that the German he learned was grammatical or socially appropriate. The situation in Germany about evening and weekend times was no different from the situation in any British unit.

In conclusion, we had a very positive experience in organising and achieving rehabilitation in a German neurorehabilitation unit. The unit was carefully chosen, based on our experience of appropriate units. There were practical issues, such as arranging taxis and ensuring that airport transportation went without hitch, but those were readily dealt with by our case manager and other staff. We have already sent one other patient to the same unit (this time for assessment and treatment planning rather than rehabilitation). We would not hesitate to make similar arrangements again.

How do you refer abroad?

Each patient is different, and needs his/her own options appraisal. If rehabilitation abroad seems appropriate, then I can certainly recommend Kliniken Schmieder (see contact details right). A further alternative is to approach the secretary of EBIS (European Brain Injury Association) and ask for advice, and for a list of EBIS members (this includes skilled rehabilitation physicians in various countries in Europe).

Neil Brooks has no financial or other interest in Kliniken Schmieder

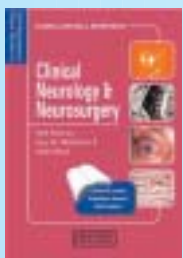
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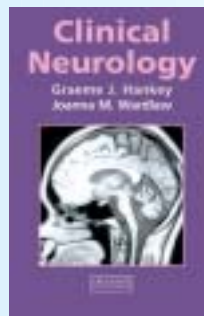


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