

# British Society of Rehabilitation Medicine/Nederlandse Vereniging van Artsen voor Revalidatie en Fysische Geneeskunde

September 23-24th, 2004; Edinburgh

This was a joint meeting of the BSRM and their Dutch counterparts.

## Chronic Pain

The emphasis of the first session was on the role of the physician in the management of chronic pain. Dr Stewart Donald started the discussion with his talk on the role of cultural influences on chronic pain. There was a particular emphasis on the role of "biopsychosocial" principles in rehabilitation of chronic pain.

Dr Charles Pither described the medical role in a multidisciplinary team pain management programme. He illustrated the danger of over-enthusiastic doctor-led investigations, jeopardising the success of a pain management programme. The purchasers and commissioners were singled out for criticism in his speech for poor understanding of this complex problem, so prevalent in Western society.

Dr P Heuts gave an overview of services in the Netherlands for chronic pain rehabilitation. Special mention was given to the cognitive behavioural programme in this setting. This innovative approach for chronic pain management included the DRAM distress risk assessment method and PHODA - photographic series of daily activities. Recent research developments, such as pain related fear and self management techniques were discussed.

The consensus of opinion was that the medical model is defunct in chronic pain, so other approaches should be used.

## Workshops

The late morning session was a choice of concurrent workshops - research methodology (Prof. L McLellan and Prof. G Lankhorst), amputee rehabilitation (Dr B Jayawardhana and Dr H Van de Linde) multiple sclerosis (MS) rehabilitation (Dr Carolyn Young and Dr V de Groot). Evidence for the benefits of rehabilitation in MS in general, as well as that of individual therapies such as physiotherapy and occupational therapy, was presented. Models of delivering a rehabilitation service in MS, both for in-patients and out-patients, were described. Dr de Groot highlighted the clinical course of recently diagnosed MS in various domains such as physical health, general well-being and social functioning. These are affected early in the course of the disease compared to mental health. The natural history of the various subtypes of MS was described, and their implications for MS rehabilitation services.

## Long-term outcome after brain injury

Afternoon sessions were divided into lectures and workshops. The first lecture was on mortality trends in the 20 years after traumatic brain injury, delivered by Dr B Pentland. The data from Scotland between 1981 and 2001 was studied in detail, in terms of the causes of death in the population with head injury. The particular role played by substance abuse, alcohol and suicides was analysed and comparison made with published data from other countries.

Prof. McLellan spoke on the long-term func-

*The Ceilidh was greatly enjoyed by all!*



tional outcome after traumatic brain injury. The literature on this complex subject has shown that many variables contribute towards influencing the final outcome, including return to work. The recovery in extreme age groups, children and older adults, show that these are more vulnerable because of the effect of maturation and ageing on the brain, respectively. The implications for service delivery of rehabilitation units were clarified.

The Dutch model for long-term outcome of stroke was discussed by Dr V Schepers, Dr J Visser-Meily, Ms M Post and Ms E Lindemen. The team introduced a new score which predicts the outcome from the point of view of social inactivity after one year, using the Barthel index, the Motricity index & the Utrecht communication observation. Factors such as gender, age, marital status were also influential, as expected. The burden on spouses and carers and depression in stroke patients one year after stroke was studied. Passive coping strategy is an important predictor. The workshop on cerebral palsy rehabilitation (Dr J Gorter and Dr R Sloan) involved a lively debate. Service delivery, transition from paediatric to adult age group, the optimum level of therapy input needed and role of specific interventions such as botulinum toxin were discussed. In some areas there was agreement but the scope of the topic was such that many aspects were not discussed in depth in the time available.

The patient pathway in brain injury, amputee rehabilitation (comparing the UK and Dutch rehab services), psychosocial aspects and cognitive behavioural therapy in cardiac rehabilitation were discussed in other workshops.

Not to mention the conference dinner & ceilidh would be tantamount to sacrilege. The social event, organised by Dr Lynne Hutton (SpR, Edinburgh) was a great success. The dinner was held at 'The Hub', once the meeting hall of the Church of Scotland. We had a sumptuous four-course dinner, the wine & conversation flowed and the after dinner speeches were well received. The ceilidh was a great icebreaker and it was a happy, sweaty crowd who made their way home at midnight, Cinderella style.

## Poster presentations

The morning session of Day Two began with presentations from nine posters chosen out of the 46 on display. The topics ranged from the practical, such as managing agitation in head

injury, to the political, looking at the application of an international accreditation process to an NHS rehabilitation unit. The prize went to an outstanding medical student from Birmingham, Miss DeSilva, who designed a questionnaire looking at 'Quality of life following amputation' in Sri Lanka. Contrary to belief, amputees were neither well adjusted, nor socially well supported. Younger, fitter soldier amputees recorded poorer functional outcomes. Validation of the modified questionnaire (Western QAL measures not relevant to SL) and further studies to identify reasons for these discrepancies are planned.

## New Guidelines

The morning also saw the launch of the Musculoskeletal Rehabilitation Guidelines by the BSRM. This much-awaited document should provide impetus to resurrect interest in this branch of rehabilitation, currently offered by a range of specialists including rheumatologists, orthopaedics, chiropractors and physiotherapists. The consensus of the meeting was that rehabilitation professionals should assume a leading role, as this patient group needs multidisciplinary care.

## Mobility and Driving

Dr John Hunter talked about the fact that while general medical advice is widely available, we need to have objective ways of assessing actual ability. In the UK, members of the Forum of Mobility Centres provide a comprehensive assessment. Dr Jos de Vries talked about the difference between driving ability (Learned experience) versus fitness to drive (Can the client compensate for disability?). In the Netherlands, an Expert of Practical Fitness assesses this ability. The Phillip Nicholls Prize-winner (BSRM Award), Dr Prasad, presented 'Driving Experiences of Disabled Drivers'. This study looked at patients who were assessed capable to drive by the Scottish Driving Assessment Service from 1997 to 2000. The majority returned to driving, but a high proportion of those with adapted controls had difficulty and only half took lessons as advised.

## Rehabilitation Technology

Dr Soede showed that emerging technologies in Tele-Rehabilitation, Supported Care & Living were not being utilised to their full potential. The Aberdeen group, led by Dr McLean, presented a novel venture between academic architects & rehabilitation clinicians, looking at the structural environment - buildings for people with physical disability and their contribution to successful rehabilitation. A presentation on Electronic Assistive Technology on behalf of an interdisciplinary working party (Dr Williams, RCP & Institute of Physics & Engineering in Medicine) focused on setting standards and increasing the availability of technology, to encourage better practise.

We look forward to the next combined UK-Dutch meeting, to be held in the Netherlands.

*Dr Pradeep Deshpande, London  
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