IDENTITY - HEALTH - WORK

" The person : the fortuitousness of his identity during the rehabilitation and resettlement process "

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(French physical medicine and rehabilitation doctor's point of view)

Philippe LERNOULD

DRUBECK, le 13.08.2004

1. Introduction

Identity – health and work ?

➢ *What allows me to share with you my reflections on this topic ?*

- I've spent 33 years among and with the handicapped people, some « life-injured » people … in a physical medicine and rehabilitation center.

- Suzanne Fouché's spirit, met in July 1968, in Peyrieu (France / 01), when I first discovered medical care of the person. She decided to trust me and employed me as a doctor for the « L.A.D.A.P.T » center.

- And my own personal and professional meetings, especially with some of my patients and some of you.

➢ *What urge me to talk about it ?*

- …Claude Robin's insistence, our center chief Executive, and some time I've spent with some of you.

- …And my personal desire to talk about it and to exchange ideas with some friends…that is to say you.

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2. The MPR – Objectives & Means

➢ The « Médecine Physique & de Réadaptation » (MPR : physical medicine and rehabilitation) is a medical specialty… used to be called « functional, professional and social re-education and rehabilitation ».

➢ It range of action covers all the issues bothering these people who face « incompleteness » due to a malformation, a disease or an accident. These people keep inability that prevents them from doing normally or correctly usual actions or daily activities, whether they are professional or social.

➢ These « inabilities » don't allow them to assume their functions, their normal role according to the norms of the social group they belong to. These people fall into situations of disadvantage (« handicap » in French).

➢ Its aims are to avoid and to put right these different states and situations by trying to give to the concerned people all the means :

• to recover or compensate physiological functions or psychological deficiencies (: but it's more the sphere of activity of the physical medicine and rehabilitation),

- to be able to restart at their best their daily activities whether they are domestic, professional or social, (: this is the field of the rehabilitation medicine),

- and then to re-integrate their own place in their usual surrounding environment, in their social group, even a professional situation (the previous one or a more adapted one), (this is then the professional rehabilitation field).

3. The regulation frame – COTOREP

➢ The 1st article of a law dated from June 30th, 1975 had established a national obligation for the sake of the handicapped people.

➢ The article #53 of a law dated from January 17, 2002, called social modernization, took back this obligation in term of citizen's chances equality :

"The precaution and the handicap hunt and the access of the handicapped person to the fundamental rights of all citizens, especially to the medical cares, to the education, to the employment, to the minimum resources guarantee, to the social integration, to the traffic and displacement freedom, to a legal protection, to the sport, to the leisure, to the tourism and to the culture is a national obligation. The handicapped person has the right to the allowance of the consequences of his handicap, whatever it can be, in order to access to the essential needs of the current life".

➢ Among the different departments from the National Health, the " Comission Départementale d'Education Spéciale " (CDES, for the minor) and the "Commission Technique d'Orientation et de Reclassement Professionnel" (COTOREP, for the adults) are two specific agencies in charge of studying the rights of the patients and the disabled people, and to tell the different orientations and decisions.

A preliminary enquiry is realized by different professionals in order to estimate the « deficiencies » and « incapacities », and mainly the possible influences and consequences of the handicap on the family, social, schoolish and professional insertion. This study takes into account everybody's situations and life project.

The study of the different files permit to face the results and conclusions of these enquiries to some evaluating tables and to some criteria's of rights allowances.

In terms of social integration, these committees impute, notably, a « carte d'invalidité » ("invalidity card") and express the different rights, especially the financial aspects and allowances and, if necessary, the eventual placements in specialized centers.

In terms of professional integration, these committees impute a recognition of the handicapped worker and propose some professional orientation in standard or specialized field or even some qualifying training.

4. The CMPR-LADAPT-Thionis

The CMPR-LADAPT, the medical center where I practice my activity, receive adults physically handicapped people following of a disease, an accident or a surgery.

We give them the means to recover their optimal functional capabilities and their daily and social life autonomy. Our goal is to permit them to restart their previous usual activities or to adapt these activities at the best. We help them in their action to look for an alternative solution for a new home or a new professional activity.

Most of the time, the main and even usually exclusive aim of the patients is to recover the use of their members or their body « as before »…. And, « we'll see later… »

On our side, we (besides the patient) try to study as soon as possible the possibilities they have to return at home, to recover their own activity, domestic, social, even professional. That's what we call the « Démarche Précoce d'Insertion » (or D.P.I, a premature insertion step, initiate by the LADAPT, on the way to be normalized by the AFNOR, the French Normalization Association).

A nurse and a nursing auxiliary teams are in charge of continuity of the traditional medical cares.

A team of physiotherapists, occupational therapists and ortho-prosthetists gives service of rehabilitation that is to say equipment needed by the patient in order to recover all his capacities.

A team of occupational therapists, social workers and if needed, a tutor for teaching general topics and a psychotherapist, is in charge of the evaluations concerning social and professional rehabilitation.

The doctors coordinate the work of these different teams and its coherence depending on the goal the patient want to reach.

There are various periods of time, from 3 to 4 weeks to 5 to 6 months, depending on the importance of the initial injuries, on the functional and social consequences and also on how difficult it is to get all the official documents together to offer the patient a viable project.

5. Some itineraries

The lecture of these following examples should be the best way for you to share my experience and to pursue my reflections.

- **Case of Mr. M…**

The story of this forty year old man is apparently the one that focused me the most on the issue we are talking about today - especially because of the sudden and unexpected way he became aware of his situation.

Married and father of 3 children, this person was staying for 2 or 3 weeks in our center for his rehabilitation. This rehabilitation was induced by some persistent backache. He had been operated twice of an hernia because of his « anté-listhésis » background (sliding of the superior vertebra on the inferior one) caused by his destitute working conditions. Roadman, he had been laying borders down for about fifteen years in a public works company. Rather depressed, he was not looking very motivated by our care.

One particular Monday morning, back from a week-end spent with his family, he asked to talk to me at once. He told me straight away : « Doctor, I realized this week-end that I wasn't a man any more… I saw my wife breaking some wood and putting it in the fireplace ! That's usually my job… You must let me go in the cabinetmaking workshop and in the gymnastics place in order for me to practice again. You must help me to recover my capacities and finding a job. »

After some professional retraining delays and a new surgery, Mr. M… has been able to get a job as a collectivity worker in a small town.

This man had totally realized he had lost his man, husband and father role because of the image his wife had given back to him by doing « male jobs », previously reserved to him. He had lost his identity, his role in the family place… He wanted us to give him the ways to get his « man identity » back. He has been able to recover his self-esteem thanks to a job that is giving him responsibilities.

- **Case of Mr. X…**

Mr X…, 70 year old, is present in our center for his prosthesis apparatus, his rehabilitation et his autonomy training. He had been amputated from the shinbone for about 10 days, due to an outdated artery problem. He is depressed on a demand and paranoid mode. He even presents some aggressive episode, demanding a lot to the nurses but also to his family. « He is no more the husband, the father, the grand-father, so good-hearted, careful and attentive we are used to seeing ».

Neither the time that goes on, nor the different attempts to go back home during the week-ends, have given any improvement. The apparatus and the autonomy recovering wouldn't be compromised ? As an inquisitive person, I ask for a geriatric examination to our geriatrician colleague. The patient comes back two weeks later to restart his rehabilitation. The therapeutic treatment has been simplified. He comes back completely transformed, the same as the family was used to knowing. « He's himself again ».

Receptive, coopering and dynamic, the rehabilitation takes place as expected. Two months later, he will be able to return back home among his wife and his children. The shinbone prosthesis is well adapted and he walks properly with a single stick. He has recovered his

identity thanks to his daily autonomy. He had succeeded in recovering his role in his family. And his family recognizes him again.

- **Case of Mr. B…**

This fifty year old driver deliveryman suffers from persistent backaches preventing him to be efficient in any activity completely disabling. He also suffers from other pathologies (a slight overweight and a blood high-pressure). The attitude of that kind is generally depressing, more or less doleful or even making a lot of demands toward the company employing him and the society in general. He's claiming full understanding and compassion.

The patient shows a certain tiredness, a loss of fighting spirit, he is even fed up with everything. He pretexts his disease, his handicap to demand his « rights » to the invalidity to the National Health. He looks for an official appreciation of his inabilities and his handicap in order to find an alternative way, another social status that could allow him to live without working. He believes he has the right to whatever he asks for after so many years of work and subscription. But he ignores the conditions of attribution and the existence of the tables that can apply to his own case. And even if he doesn't' have the right to, we would nevertheless ask for a financial help…we never know ?

This man identifies with his disease, with some others disabled people like him who received the invalidity card. He appropriates himself subjectively the status of handicapped and invalid person without taking into account the fact that there exists a law that defines objectively the conditions of attribution of this recognition and the rights that are going with.

He belongs to this kind of people that feels « used » by the work and the time. He's also discouraged by the system of production- consummation that runs over him and doesn't let him the choice…He tries to use another system, the one of the social protection in order to find a new situation, another social recognition…to the price of the desolation of a part of his identity.

There exists for a matter of fact a real issue on which we are thinking about with a sociologist from the faculty from Metz on the subject «back ached workers versus back ached patient ». This work is based on personal lengthways enquiries and also on statistics resulting from a 325 people sample that spent a period of time in our rehabilitation center from LADAPT-Vernéville between 1997 and 2003…

6. Some afterthoughts & personal reflections

The following afterthoughts result from such itineraries and from my own experience. Other development are for sure possible. The exchange we'll have after this presentation will certainly enrich the debate.

Firstly, I've observed and I'm personally convinced that doctors, like all the therapeutics and members of the medical teams, use words that can be misunderstood by the patient. Indeed, everybody puts the meaning he wants to, to the words because of its own knowledge and

experience. Everybody can interpret the words depending on his own desire. Then, words can take some completely different meanings between the doctor and the patient. What do we ourselves mean when we use this or this kind of word ?

The so usual use of some of these words is most of the time terribly common in our daily job. In particular, I think of words and notions used during all these days, for example :

1. The identity – the identification.
2. The health – the disease – the handicap – the incapacity.
3. The work – the employment – the activity.

I let you find these meaning in the dictionary, as I spent time to do so to prepare this presentation. The dictionaries themselves give different meanings for a same word. You will discover some general definitions and others more particular, and their evolution in the time… what only contributes to the confusion. That's really "Babel" !!!

Process Disease > Incompleteness > Inability > Handicap

In fact, what's going on for the healthy that becomes sick or handicapped.

He loses his health and some of his capacities to realize his usual activities that allow him to conserve his social role.

Until now, he was living in a sense of well-being, in a more or less balanced equilibrium of his organs and the way they work, in the "silence of its members" . He was able to assume the usual acts of his daily life and the activities of his social and professional life (this independence is nevertheless relative to the human normal interdependence).

The idea and feeling he had about him are disrupted. The image and the esteem he had about himself are deformed. He suffers from this, without talking about his possible physical pains. Impotent, he assists to the decrease or the lost of some of his capabilities. He becomes more and less dependent of a trick or a third person to perform certain acts, gestures, to realize certain functions, certain activities… that were easy and usual.

If the disorder is pointed and temporary, the process is relatively simple. It can be reversed more or less rapidly. The patient will be able to recover his previous activities and his social situation. In the future, the event will perhaps be forgotten or not, depending on the acuteness, the gravity, the duration of the disease and its impact imputed by the patient himself.

If the disorder becomes chronicle and mainly a handicap, the echo can be more consistent.

The patient will eventually be annoyed in some of his assurances and some of the things he's used to doing or seeing. He will have to work on himself in order to "have a clearer sight" on what arrives to him and on what is expecting him. In a first period of time, he will have to forget the previous period of time, his place, his role, his previous situation. He will have to face one or several classical phases (denial, anger, depression, acceptance).

In a second period of time, he will have to build his future on new bases. He has to recover a new status, a new value for himself but also for the image he reflects to the others. If his physical or psychological modifications don't allow him anymore "to be the same" and "to do like before", he doesn't loose his personal identity as far.

The specific individual characters linked to his birth (sex, last name and first name,…), his personal identification declared at the town hall to identify him, and all his identity's documents stay identical and unchanged.

On the other hand, he will have to consider his function and his social status in a different way. He has to review his insertion that is to say his social identity.

He will have to recover his place in his family, in his social group with his new capabilities… but mainly with some inabilities. He will have perhaps to learn how to be different with his wife and his family. He will sometimes have to change his job or to modify it to be able to continue to practice an vital economical function. The different activities will have to be adapted if he wants to stay active and present at his maximum in his associative engagement.

The easiest social identification is to belong to a social group that recognize the person as being part of them. Now, one has to do everything that is possible to recover a job, a "socio-professional" and economical "value" defined by this group.

A professional and paid activity may not be possible anymore, he will then have to find one or several economic alternatives. This will be, for example, the remedy to the unemployment or the invalidity card…having no other solution.

In our French social system (from what I know, by experience), the law and its application - founded on the national solidarity principle - recognize the status of sick person, invalid, handicapped worker or handicapped person… Such a status allows to impute rights to a certain category of people, who, because of a disease, an accident or a handicap, are not able to integrate the society. These persons have nevertheless to be identified like that. Some of them, more or less unconsciously, look for entering a certain group a handicapped or invalid people. They want in fact to obtain the same rights offered to these people : a status, a gratitude of their state, but also the financial advantages linked to this gratitude. Some of them certainly need this financial help. But some others use and abuse : they even put forward their invalidity card like others show their identity card ! Some others use it as a "sesame" , or even as a real "right-pass" !!!

Re-education, rehabilitation and resettlement process

The assistance in the physical medicine and rehabilitation is premature, global, continuous and dedicated. It can only be realized by a coherent team. It needs most of the time the help of specialized partners, that come from outside the medical structure.

Its aim is to answer all the needs of the patient by offering him the means to recover everything, in order to rebuild the puzzle.

The physical or mental injuries have sometimes damaged the body of the patient and its functions. He doesn't recognize him anymore, its surrounding doesn't recognize him neither. He's not like before, he's not the same anymore. He has lost his physical integrity, a part of his identity. He has to face " an identity crisis " that is more or less difficult, depending on how the patient feels his body and his personal identity.

These injuries, this incompleteness are diagnosed and evaluated by the doctor. He organizes and coordinates the different medical cares. The different expressions (whether they are verbal or not) used by the medical environment will be reassuring, they will be anyway interpreted.

If the recovery is complete or at least if the patient can restart his previous activities, this crisis will be short length without any consequence. The picture and the identity card will not need to be changed…

These imperfections can induce some moderate but real incapacities. They will then need some organization in order for the patient to reintegrate his place in his usual social group. The patient will nevertheless have to reconsider some of his previous activities, his situation and his social role.

The professionals of rehabilitation will help the patient to learn how to use physical allowances or technical assistance appropriated to his new health state. The rehabilitation team will propose and cause some meetings with the family, a visit of the patient's house or the company he works for in order to evaluate and organize his come back at house or at work.

Some more important injuries and incapacities can require more radical solutions. The family will for example have to change the residence in order to be accessible. The patient will eventually have to change his job or his company.

The "identity crisis" takes some social dimensions in addition to the physical dimension. His social status will be modified. The person was mason or artisan, he was living a house where he had his uses, where he knew everybody et everybody knew him… He will have to rebuild his situation, his social and professional identity by moving in an accessible building in an other place and as a new worker for example a community worker.

The handicap with aftermaths can stay very severe. With many consequences, it doesn't allow any recovering of any professional activity. In a more extreme situation, the physical or moral independence can stay more or less compromise and can require an assistantship of a third person for the daily life.

The medical care teams will have to help the patient to forget he doesn't have the previous capacities anymore. The doctor, the psychologist and the social assistant will "escort" the patient to recompose his new state, his new situation, his future identity of a dependent person : dependent of his family circle, of the medical cares and some social organisms. This work can be long, even sometimes never completed, depending on how much the patient was implied in his previous situation.

Then will arrive the question of a new status and identity of the patient, of a handicapped or disabled person, of an invalidity card, of a pension, of the aid centers,…in front of a society founded on a well-known “production-consummation” system.

For some of these disabled persons, it’s then the start of an exclusion : the patient can fall into depression or can even think about the suicide… We become aware of how usefully it is for the patient to meet other people. Some patients enter as many associations as they can in order to satisfy their need, to find a place among other people, to be in the action…

To be or to have ? - To have or to be ?

I think that for some patients, the use of the verb « to have » or the verb « to be » gives a different meaning to their expression.

- To have a disease -- to be sick
- To have a handicap -- to be handicapped
- To have the health -- to be in good health
- To have capacities or incapacities -- to be able or not able to
- To have a job -- to be employed
- To have the quality of handicapped worker -- to be known as handicapped worker
- To have the invalidity -- to be invalid

8. Conclusions

- <<< "The other is another who is other just because of he is at the same time such and different" – Vladimir Jankélévitch

- <<< " I is another…in another way " - ?

To conclude this short presentation, I would like to share you these afterthoughts.

- The identity of a person is a progressive building that start from his birth. It makes from everybody a unique person and makes him belong to a group.

- The first thing we do when someone is born, is to identify him that is to say to give him an identity. The first identification is the sex, then the first name and finally the last name as it appears in the civilian statement and which makes him belong to a group.

- This "paradoxical" registration in a group follows the person during all his life. He has to find the balance between his uniqueness to exist and his similarity with others to guarantee that he belongs to a group.

- Health and work are some integration standards in our society. They constitute some identification factors . If we loose these standards, we have to face the exclusion.

- Sometimes the disease and the handicap break the physical or moral integrity into pieces. The induced incapacities can slow down or stop the access to the job market.

- Today, the professional insertion of someone induce his social insertion. In our westerner society, work contributes to the social gratitude. It brings money. It is a the same time a criterion and a factor of autonomy that is to say a way to integrate the society.

- The most handicapped persons are called “excluded” because of they don’t work are because of they can’t afford a house rent, aren’t they ?

- The invalid or handicapped person has to recover new means to live. He will have to look for another identity in this society… in order to recover a small place, a folding chair !

- Presently, our society imputes the patient a new status, gives a new social identity… new rights, various allowances in order to subsist, invalidity cards, financial aids because of unemployment…like his identity card.

- In fact, laws and numerous assistances exist. Multiple associations, specialized centers and qualified persons work for vulnerable children, men and women in order to help them to surpass their difficulties, their handicaps and to forget that they suffer. But an evolution of the attitudes will have to follow the evolution of the text law in order to make the application of the laws and the equality of the chances easier.

- This challenge is the one of the fraternity and the solidarity. I’ve never seen a successful outcome in term of rehabilitation and insertion without a big dose of tolerance and conviction.

- We have especially to believe in Human, so that everybody – whether he is handicapped or not - worker or not – is able to find his place and his self-esteem.

- … on this really note, I met handicapped persons who were happier and more spread out than other valid people… without any identity problem.

- … that’s the one of the faith in life..

- … on another song : "Va, ta foi t'a sauvé" ! (Go ahead, your faith saved you)

- … on the music from : "Je suis celui qui suis" ! (I’m the one who is)

But… this would be another debate, if not a same fight, wouldn’t it ?

Ph. LERNOULD