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Foundation for History of
Physiotherapy **Physiotherapy in perspective, 50 years past - present.**

Rehabilitation centers arise in the Netherlands

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Introduction

The first functioning rehabilitation center in the Netherlands was the Aardenburg Rehabilitation Center in Doorn, which was established to provide assistance to victims of the Second World War.1,2

Rehabilitation center Aardenburg in Doorn in 1946

The pioneering work came from the first rehabilitation physician in the Netherlands, Dr J. van Gogh (born 1913). He trained as a remedial gymnastic masseur (1937) and passed his medical exam in 1946.1 Dr. van Gogh was called up in 1945 for the military service that he would fulfill as a rehabilitation doctor at the Rehabilitation Center Aardenburg in Doorn with the order to rehabilitation center after English example to start.

The first definition of rehabilitation was (1946): *"Rehabilitation encompasses all measures aimed at anatomical and functional recovery, the recovery of fitness for work and reintegration into the labor process".*

3

After only a few years, this center was declared one of the best in Europe, where Van Gogh developed occupational therapy for spinal cord injury patients and patients with an amputation, among other things. 4 dr. Van Gogh, along with Dr. de Groot and Dr. Miedema, was considered one of the first generation of rehabilitation physicians. One of his students, Te Riele, described Van Gogh as *"the godfather of rehabilitation in the Netherlands"* 1

Return to society as a condition of rehabilitation.

Yet rehabilitation centers did not originally lend their existence to 'care' or 'cure', but the question was how do we eventually get patients back to work? In 1946 the *Council* was

for the recovery of fitness for work (RHA) and advice was given on how to set up rehabilitation centers for victims of the 1 A Second World War also took place.

Polio epidemic in 1956 played a major role in continuing to develop new rehabilitation centers.

It was clear that the Netherlands was lagging behind international developments at this time. It was therefore decided to send two subcommittees to England to study rehabilitation centres. These subcommittees would

figuring out how the construction and design of rehabilitation centers should take shape

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and how soon a national organization of rehabilitation could get started.
The council decided in March 1947 that more rehabilitation centers.
Huize De Hoogstraat would be set up as an emergency center for the middle and north of the country.

Rehabilitation center 'Huize de Hoogstraat' in 1947.

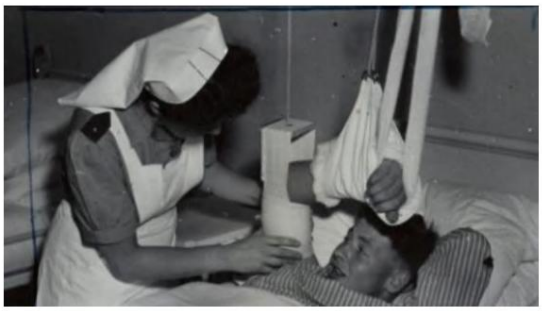
The *Sint Maartenkliniek* would serve the south of provide rehabilitation care to the country. Followed third by the Muiderpoort Rehabilitation Institute, which opened its doors in 1951.1

Rehabilitation center Muiderpoort Amsterdam

Initially, however, only war victims were eligible for a rehabilitation center. For example, civilian patients with a spinal cord injury were not eligible for admission to a rehabilitation center until 1949.

Building a multi-disciplinary team

In these rehabilitation centers, different disciplines, such as a nurse and a remedial gymnast, masseur, would be working to treat patients in close collaboration.



Nurses were the care professionals from the very beginning in rehabilitation.

This setup had both advantages and disadvantages. The advantage was that the different disciplines could learn more about each other's profession. The disadvantage was that people were not used to “working together”. In addition, every discipline was still in a separate wing of the building.
Loes Jalink, physiotherapist, speaker at the Urkdag in 2018 already indicated during her lecture: cooperation as we know it was not possible in the early years of rehabilitation, if only because of the construction of the rehabilitation centers at the time (separate wings per discipline). . Another disadvantage was the shortage of medical specialists in the field. At that time there was no training for rehabilitation physicians and no specific follow-up training for physiotherapists.

Exercise room (healing gymnastics) in the early days of the revalidation

Slowly more and more disciplines seeped into rehabilitation. In addition to the remedial gymnast, an occupational therapist (later called occupational therapist) was also appointed.

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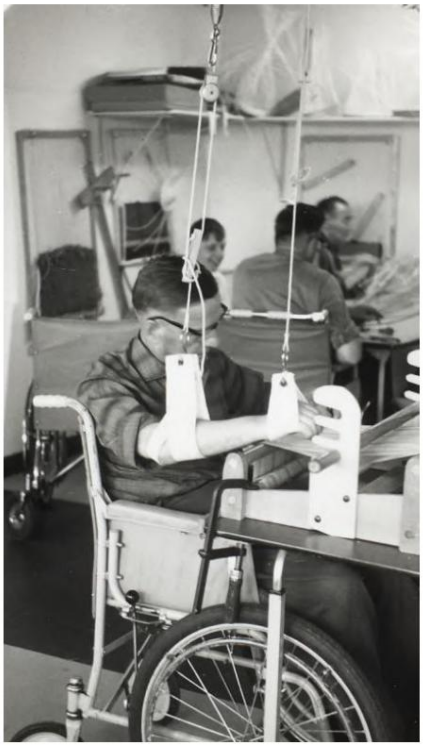
Occupational therapist, pioneers in rehabilitation

In 1949 it was concluded that the patients not only needed physical care but also needed mental support. For example, the army chaplain was added to the staff and in 1950 a chaplain (clergyman for soldiers) and later the pastor. Social services expanded as the

efforts to find suitable work for the patients increased and the social worker stepped in.

Later on, disciplines such as psychology and socio-cultural work also emerged in the rehabilitation of which the social-cultural worker (welfare work) has since disappeared again. Due to the expansion of sports facilities for rehabilitators, exercise agogy has undergone a major development that is indispensable in current rehabilitation centers.

More and more disciplines followed such as the social worker, occupational therapy, speech therapy, dietetics, hydrotherapy, occupational therapy, etc. Multidisciplinary work, for example, was increasingly given shape due to the multiplicity of disciplines, whereby different treatment visions had to be integrated into a joint approach. Working with a care plan and established multidisciplinary care paths in which the patient is central.



Occupational therapy department in the early days of rehabilitation

How did the rehabilitation go?

The rehabilitation doctors have done a lot of work to finally get the rehabilitation recognised. In 1958 the rehabilitation doctor was officially recognized as a medical specialty and there was still a lot of unknown in the medical world about what exactly was done in the rehabilitation centers. For example, Prof. Dr. A. Prevo, rehabilitation physician Heliomare, in an interview that he once had a patient referred by a medical specialist with the request to repair a wheelchair (a screw was loose). Hilarious but also indicative of the unknown

at the time of the rehabilitation domain. The rehabilitation industry grew into a broad field of work, partly due to all technological developments (rehabilitation technique, prosthetics), vocational education, mythyl schools, research departments, etc.

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Healing gymnastics is entering rehabilitation

Currently, the Netherlands has many rehabilitation centers that all have their own specialization and history. They have organized themselves in a trade association,

Rehabilitation Netherlands (website: https://www.revalidation.nl/). Also, there is currently no longer talk about rehabilitation but about 'medical specialist rehabilitation' because the centers only focus on highly complex care (Stepped Care).
The professionals further organized themselves into professional associations. In 1955, Dr. De Groot and Dr. Miedema the *Dutch Association of Physicians for Rehabilitation and Physical Therapy* founded now the Association for Rehabilitation Doctors (VRA, website: https://rewaardenbedrijven.nl/) and the physiotherapists organized themselves in the Dutch Association for Rehabilitation Physiotherapists (NVRF, website https://nvrf.kngf.nl/) in 2011 who wish to initiate training for rehabilitation physiotherapist.

What can we learn from it?

First of all, that the role of the remedial gymnast masseur was very different in the beginning than in a hospital at that time. Earlier it was discussed how the chairman of the Dutch Association of Physical Therapy, mr. Nuyten, a huge plea had to be made for the importance of physiotherapy in hospitals.5,6 The reverse was the case in rehabilitation. The pioneers Dr. van Gogh, remedial gymnast, rehabilitation physician and Dr. de Groot (also a remedial gymnast and rehabilitation doctor) received an order from the government to develop a rehabilitation center for foreign countries (England). example in which the multidisciplinary character was and is a given. Would we like to see these kinds of major initiatives again?
If remedial gymnasts such as Nuyten and Van Gogh were alive today, they would perhaps like to place the epidemics of our time, the diseases of affluence (including metabolic syndrome, diabetes mellitis type 2, obesity, lack of exercise, etc) in specialist centers. But it doesn't work that easily these days. Because there is coming

We are increasingly looking at the responsible organization of highly complex care (medical specialist rehabilitation).

The philosophy of the current architecture of healthcare institutions has not stood still either. New care centers are now only built with multi-disciplinary teams around the patient

(Source: TU Delft Architecture). [7] It is impossible to imagine life without multidisciplinary work and is also spreading to primary care . Prof. dr. Dr R. Engelbert already indicated at the annual study day in Urk that a monodisciplinary product will belong in the display window of the historical museum. In fact, he wondered whether physiotherapy would still exist in the long term because of all the new knowledge we now have about nutrition, lifestyle and genetics.
In any case, we must look for first - line cooperation in physiotherapy with other disciplines; physiotherapy can be a co-initiator in this, so that specialist care is no longer reserved for large centers.

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Photo material: Annemiek van der Schaar, spiritual counselor Heliomare, Wijk aan Zee.

Info: Foundation for History of Physiotherapy: http://www.sgfinfo.nl/