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When travel is a challenge: Travel medicine and the 'dis-abled' traveller☆

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ABSTRACT

Travellers with recognised disabilities or the dis-ability to function as required during a trip have been overlooked in the travel medicine literature. This paper provides a starting point for further discussion and research into this neglected traveller population. In contrast, tourism research has explored travel with a disability for some time in order to understand the travellers' needs and to improve services accordingly. The contemporary bio-psycho-social understanding of disability serves as the framework for exploring motivations to travel as well as barriers, such as inter and intrapersonal, economic, structural and attitudinal obstacles. The demands of complex travel planning are acknowledged. Attention is also drawn to the particular issue of acquired disability. The theoretical discussion is complemented by travellers' own accounts using as examples mobility impairment on aeroplanes, sensory impairments, and obesity.

These insights should inform high quality travel health care starting with an exploration of the health professionals' own views on such endeavours. Important are appropriate communication skills, an understanding of the travellers'/carers' views, wishes and judgment of abilities, as well as the appreciation of the reason for the trip, destination and planned activities. Challenging may be the need to accept that the traveller/carer will be more knowledgeable about the disability, needs, potential problems and solutions than the health professional. Finally, medical requirements for destination and activity need to be combined with the medical requirements for the dis-abling condition. Scarce literature and increasing numbers of travellers with disabilities should make this field a research priority in travel medicine. Unless there is an absolute medical contraindication, travel health professionals should encourage and support travellers for whom travel is a challenge.

1. Introduction

Every now and then, media headlines report on sensational travel by disabled people. A man without legs crawling on his hands up Mt Kilimanjaro, a quadriplegic in a wheelchair making it to Machu Picchu, or a man without limbs traveling around Southeast Asia. The ultimate challenge, of course, is being the first on Mt Everest; the first disabled person, the first blind person, the first with multiple sclerosis, with amputations and so on and, once these spots are taken, the first women or the first representing a country in a particular disability. In contrast to these much publicised achievements of individuals, thousands of disabled athletes travel every year to large international sporting events, such as the 2016 Paralympics in Rio de Janeiro or, in 2017, the Deaflympics in Turkey or the Special Olympics (for athletes with intellectual disabilities) in Austria.

Globally, according to the WHO [1], one in seven persons is disabled, many of whom travel. Yet, this group of travellers seems entirely overlooked in the travel medicine literature [2]. Even the relatively frequent papers on disabled sporting events provide, puzzlingly, only general travel health advice for mass gatherings [3,4]; the disabled athletes or visitors are not mentioned.

The purpose of this paper is to remedy this shortcoming by providing a starting point to encourage more and specialised publications as well as research into this neglected traveller population. Before discussing the contemporary view on disability, this is a good time to pause, reflect about one's own past travels and imagine them had one been disabled, e.g., blind or in a wheelchair. It is particularly useful to picture practical details, such as sitting through a 14-h flight, boarding a train carriage, experiencing the narrow cobblestone lanes of a historic town or visiting an iconic attraction, and to assess if or how that trip would have been difficult, if not impossible.

1.1. Disability: an evolving perspective

Previously, a medical model of disability focused strictly on medical defects in need of intervention. This view had been replaced in the 1980s by a social model which included social and environmental aspects. The current World Health Organisation (WHO) definition of

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Table 1
WHO definition of disability.

Disabilities is an umbrella term, covering impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations.
Disability is thus not just a health problem. It is a complex phenomenon, reflecting the interaction between features of a person's body and features of the society in which he or she lives. Overcoming the difficulties faced by people with disabilities requires interventions to remove environmental and social barriers.
People with disabilities have the same health needs as non-disabled people – for immunization, cancer screening etc. They also may experience a narrower margin of health, both because of poverty and social exclusion, and also because they may be vulnerable to secondary conditions, such as pressure sores or urinary tract infections. Evidence suggests that people with disabilities face barriers in accessing the health and rehabilitation services they need in many settings[5].

disability [5] (Table 1) highlights this changed approach. Its focus on participation and health needs is relevant to travel health and medicine.

In 2001, the WHO acknowledged this inclusive perspective with the International Classification of Functioning, Disability and Health (ICF) which incorporates, based on a bio-psycho-social model, the overall categories 'body functions and structure', 'activities', and 'participation', as well as contextual (environmental and personal) factors [6,7]. It provides an international standard language to describe, classify, organise and code disability. The 2006 UN Convention on the Rights of Persons with Disability [8] in Preamble (e)

> Recognizing that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others

and in Articles 25 (Health) and 30 (Participation in cultural life, recreation, leisure and sport) supports the contemporary understanding of disability and provides important parameters which also apply to travel medicine. In 2011, the WHO, together with the World Bank, released the comprehensive World Report on Disability [1] though omitting travel as such. However, it does mention disabled people's increased rate of health risk behaviour, greater risk of being exposed to violence and higher risk of unintentional injury as well as environmental barriers which are all of relevance to travel.

Regardless of the ICF, numerous lists and classifications of varying degrees of detail exist for various purposes for governmental social services, insurance companies or memberships, constantly evolving due to increasingly refined diagnoses and reclassifications. However, such detail is less relevant when it comes to the ability to undertake travel. Returning to the mental exercise suggested earlier, the question is: what is it that proves difficult or impossible to do while traveling? What are people not able to do? How does this 'in-ability' or 'dis-ability' impact on travel? Therefore, we should consider restrictions to functional abilities (congenital or acquired) required for meaningful travel, including the ability to move, commute, participate or complete activities of daily living (= dis-ability), not just officially recognised disabilities. Table 2 provides broad categories of practical functional challenges relevant to travel acknowledging WHO and UN guidelines with the aim of enabling participation in the tourism experience.

Not surprisingly, there is a considerable amount of work in tourism academia where the aim is to understand traveller and travel context to provide appropriate services. Equally, in order to provide high quality travel health care, it is crucial to understand the wider context of the disabled traveller as it is the person who travels, not the disability. Understanding the motives for travel as well as the challenges gives clinicians an opportunity to support the traveller in this endeavour sympathetically.

Table 2
Examples of dis-ability relevant to travel and tourism.

- Physical restrictions to full functioning (also requiring the use of wheelchair, artificial limbs, walking stick/frame/crutches/appliances, e.g. for arthritis sufferers).
  - o Paralyses, amputations, spinal cord injuries, cerebral palsy, muscular dystrophy, multiple sclerosis, Guillain-Barré Syndrome; underlying conditions, e.g. diabetes, cancer
  - o Rheumatoid arthritis
  - o Obesity
- Travellers recently incapacitated (major surgery, plaster casts)
- Sensory impairment (vision, hearing)
  - o Degrees of vision impairment; colour blindness?
  - o Degrees of hearing loss; vestibular loss
- Cognitive impairment, intellectual impairment, development disorders (e.g. autism), brain injury
- Psychiatric disorders
- Dementia

2. Motivations to travel

Apart from the many general reasons for travel, many people with a disability appreciate even more the positive effects of travel in relation to being free, in control, being 'able', gaining self-confidence and overcoming self-doubt. The notion of escaping, getting away from the usual care environment, but also from being 'objects of care' has been reported frequently [9–11]. A satisfactory leisure component was not only rated highly by people with physical disabilities but led to a reduction of secondary health problems [12]. Travel also broadens young people's social life [13]. For families with disabled children travel not only offers relaxation, escape, socializing and family closeness but the ability to nurture, improve, develop and challenge the children's intellectual and physical competence [14].

3. Barriers to travel

From the late 1980s to today, barriers to travel have been researched, yet, despite more awareness and some improvement, little seems to have changed for the travellers.

3.1. Intrapersonal/intrinsic factors

Here, the traveller's physical, sensory, psychological, emotional, social and cognitive abilities may pose a barrier to contemplate travel. Especially if these factors have led to a sense of restriction and dependency, it may be difficult to overcome such restrictions [15–17].

3.2. Interpersonal/interactive factors

Travel requires interaction with travel companions, service providers, strangers, the transport and destination environments including negotiations and compromises with people and places. 'Making do' when a problem occurs or actively seeking assistance are part of such negotiations [15–17].

3.3. Economic factors

The cost of travel is often much higher for people with a disability, such as the need for additional help or modifications for travel. Suitable accommodation is usually only available in more expensive establishments as cheaper (backpacker) accommodation is often in older buildings with narrow staircases and corridors. Modified hire cars may not be available, and a carer's travel costs may have to be covered. Additional needs for specific equipment or assistance animals add to the expense [18,19].