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RHEUMATISM: A NATIONAL PROBLEM

BY
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The Heberden Oration was instituted in the year 1938 and was first delivered by Dr. Ernest Fletcher in May, 1939, who took as his subject "The Association of Osteo-arthritis with Obesity and Hypertension". The second Oration was delivered 2 years later by Dr. W. S. C. Copeman, on "The Treatment of the Rheumatic Diseases in the B.E.F". The war and its aftermath brought a hiatus of 9 years, and in 1948, Professor Hench delivered the Oration on the now historic subject of "The Potential Reversibility of Rheumatoid Arthritis". In 1949, Professor Wood Jones spoke on "Classical Gout"; in 1950, Professor Selye's topic was "The Rheumatic Diseases of Adaptation"; and last year Dr. Kendall addressed us on "The Adrenal Cortex and Rheumatoid Arthritis".

In face of this array of significant themes, dealt with by such eminent colleagues, I feel that both the orator and the subject to-day will be regarded as somewhat banal. For the orator I have no apology; for the subject I hope to make good the claim that the national importance of rheumatism should be once more stressed, and the position re-surveyed.

By the word "national" I do not mean "governmental", although there is nothing of national interest which should leave a nation's government unconcerned. By national I mean "appertaining to the community in general", and to all its citizens, both as individuals, and as social and economic units. *Pace* that view of a welfare state which looks to government to lead the individual's life for him, health and happiness are the result, in this country, of joint efforts by persons and by groups, encouraged and sponsored by a government with vision. Now and again it becomes obvious that some hold-up in this matter of health and happiness calls for special attention, both on account of its magnitude and the need for intensifying and co-ordinating the various efforts that are being made to deal with it.

When the Empire Rheumatism Council—to which, in 1946, the Heberden Society became affiliated as its clinical section—had conducted an intensive campaign for 4 years into the causes and treatment of rheumatic diseases, it suggested a plan

of action on a national scale, which should combine research, prevention, and treatment.

This plan was the result of knowledge gained by laboratory and clinical research, by the study of existing rheumatic centres at home, and by a close examination by travelling fellows of the Council into the methods of some of the chief rheumatic clinics in Europe and America. The plan was published in 1941. It was prefaced by a statement of the gravity of the problem presented by rheumatic disease and the toll it exacted in pain, disablement, and economic loss. The figures were cautiously chosen. They were supplemented by Professor L. S. P. Davidson's investigation in Scotland, and subsequent estimates have not led to any material modification.

The figures were so tragic that it is difficult to say why this problem of rheumatic disease had been thus far neglected. I can only advance the same two reasons to-day as I did then—its low mortality rate, and the lack of the dramatic note in its appeal.

The plan received a good deal of attention at the time and most criticisms of it were favourable. It certainly had the merit of simplicity. Was it, perhaps, *too* simple to be convincing? However that may be, this particular blue print received ministerial recognition and had the support, in principle, of that wise and far-seeing Chief Medical Officer, Sir William Jameson. There had recently been set up an advisory committee on rheumatism at the Ministry of Health and the plan came to be regarded as the prototype of what might be done in this direction under an already envisaged National Health Service Act.

We had two distinct sets of material—the juvenile patient and the adult.

For the former the rheumatic scheme of the London County Council Medical Authority provides an excellent model. Its basis is the routine inspection of all children at entrance and at three subsequent stages in their school life. Then come three supervisory rheumatic centres, one for children with a history of acute or subacute rheumatism or chorea, one for children having symptoms suggestive of a mild rheumatic infection, and one for suspected

cases awaiting diagnosis. These centres are supplemented by rheumatism units for more prolonged treatment and oversight, and for the amelioration of home conditions when necessary. This scheme is local, but it might, and we think should, be national. It is expensive but the money is wisely spent.

It was in the treatment of the adult and more chronic rheumatic sufferer that a new scheme was urgently needed. It had been estimated that less than 10 per cent. of the total number of rheumatic patients in England and Wales obtained special treatment in the early stages of their disease. Yet there was good evidence that the results of early treatment of these patients might be very helpful. This was shown to be the case at Buxton and Bath, in three large London Clinics, and in at least one rheumatism centre in the United States.

With the object of embracing this whole class of patients the plan outlined the following machinery:

(1) *Specialized Treatment Centres.*—Specialized treatment centres should be set up on a regional basis at a teaching hospital of university status. The functions of such centres would include the diagnosis and treatment of cases, of both in- and out-patient type, referred by local treatment centres, by other hospitals, or directly by private doctors; the education of the patient in "home therapy"; the investigation of new methods of treatment referred from any competent source; the institution of post-graduate courses in the diagnosis and treatment of rheumatic diseases; the provision of visits by consultant specialists to local treatment centres within its region; the advising of local treatment centres in regard to staff and equipment; the training of physiotherapists in co-ordination with the Chartered Society of Physiotherapists; and co-operation in research into the causative factors of rheumatic disease.

The chief desiderata of a specialized treatment centre would be:

- (a) facilities for enrolling a full staff of consultant specialists, physicians, and surgeons, including an orthopaedic and manipulative surgeon, a dentist, a gynaecologist, a rhinolaryngologist, a pathologist, and a radiologist;
- (b) in-patient accommodation, either on the site or conveniently accessible;
- (c) association with a university medical school and a fully-equipped and staffed laboratory and with an efficient x-ray department.

A specialized treatment centre should have, in addition to the specialist physician in charge, a whole-time permanent medical officer with special experience in rheumatic disease, and a staff of qualified assistants, paid or voluntary. The auxiliary staff should include workers in every branch of physio-therapy, radiology, hydrology, and chiropody. At least one of its members should have a full nursing qualification.

Such centres should have additional "base" beds in one of the lesser regional hospitals, where long-term cases could be treated and rehabilitated.

(2) *Local Treatment Centres.*—In every region having a specialized rheumatism treatment centre, there should be established local (peripheral) treatment centres. These should be in sufficient numbers and so situated as to provide treatment facilities in conveniently accessible places. The equipment of a local treatment centre might be arranged for from 50 to 250 patients a day.

Equipment should provide for massage and remedial exercises and for the simpler heat and electrical treatments. Sites for treatment centres would be usually found at hospitals, pit-head baths, public baths, welfare premises of industrial enterprises, and other public or semi-public institutions. These centres would be planned for out-patients only. In-patient treatment would be arranged with the regional treatment centre.

Regular skilled medical supervision is essential. The medical supervisor would not necessarily be a whole-time official in a small centre, but would be employed half-time, or even quarter-time, fitting in his duties with other practice, or preferably sharing his time between two, three, or even four local treatment centres. He would thus gain more experience of rheumatism. It was thought important, from every point of view, including economy, that the practitioner in charge of a local treatment centre should have, in addition to his standard medical skill, special knowledge of the diagnosis and treatment of rheumatic disease. Patients would be accepted only on recommendation of their own doctor. They would be, as regards special rheumatism treatment, under the control of its medical officer; as regards other health matters, they would remain under the supervision of their family doctor. It would be necessary, however, that the medical officer of the local treatment centre should have the power of decision whether a course of physical treatment was necessary and what type it should be, to avoid waste of resources.

One of the functions of the local treatment centre would be to seek to educate those with whom it came into contact, about the faulty conditions of living—housing, diet, clothing, social habits generally—which are conducive to rheumatic disease, and to give common-sense advice on prophylactic measures.

It will be seen that the chief purpose of the plan was to divide patients into three sections:

(a) those who, with a very brief period of institutional treatment and a sound course of physical education, would be enabled to carry on chiefly by simple home treatment supervised by periodic visits to a local treatment centre or by skilled social service workers;

(b) those who could secure adequate treatment, without much disturbance of normal life, by attendance for the necessary term at a local treatment centre;

(c) those who required hospitalization, rehabilitation, or attendance at a specialized treatment centre.

One difficulty had to be faced at the outset. The number of doctors with special knowledge of rheumatic disease was limited. Our plan was consistent with our existing medical system, which assumes on the part of the general practitioner a sound knowledge of the principles of medicine and surgery and

an acquaintance with the common types of clinical material. The best resource of any sufferer, at least in the first instance, is the family doctor. If we do not accept this we deny the efficiency of our whole medical system. We sought to reinforce the general practitioner's knowledge by short post-graduate courses in rheumatism, and to encourage young specialists in this field.

I do not apologize for taking this step back and looking at the plan afresh, because I want now to see how far we have gone on from there. This question may be answered from several sources. There was an interim report, if I might call it so, provided by Sir Henry Cohen in his stimulating Samuel Hyde Memorial Lecture, given before the Section of Physical Medicine at the Royal Society of Medicine 6 years after the plan was published: Sir Henry had taken the chair at the Minister of Health's Subcommittee on Rheumatism for the previous 3 years; there is the Section on Rheumatism in the successive Reports of the Ministry of Health for the years 1945-51; there is the Report of the Chronic Rheumatic Diseases Committee of the Royal College of Physicians published in 1952; and there are the replies of the Regional Representatives of the Empire Rheumatism Council to a questionnaire on the rheumatism facilities in their regions.

I propose to draw briefly upon all these sources in order to see clearly where we stand to-day.

Turning first to Sir Henry Cohen's lecture, which he aptly calls "a challenge and an opportunity", though he made no reference to the plan of the Empire Rheumatism Council, he was clearly stirred by a desire similar to ours to alleviate the sufferings of what he so fitly called "medicine's neglected step-child—the rheumatic diseases". He dealt even more fully than we had done with the size of the problem and concluded that the position called for action in four directions:

- (1) research into the problems of rheumatism;
- (2) planning a service which makes all necessary treatment available to all who need it;
- (3) stimulating in students and practitioners a greater interest in the scope and methods of diagnosis and treatment of rheumatic disease;
- (4) making available opportunities for the training of those who wish to specialize in this field.

To fulfil these desiderata, Sir Henry suggested a plan for "immediate action", in every essential respect the same as the Empire Rheumatism Council Plan. There is, perhaps, a difference in this respect, that Sir Henry did not specify that there should be a special centre at the teaching or major general hospital where diagnosis and research should go on, whereas we had considered this important so as to

secure the necessary linkage with the smaller clinics and with the base hospitals where long-term cases were under treatment.

This lecture supported our advocacy of an attempt to grapple with the position immediately, without departing from the accepted principles of our system of medicine.

Let us now trace the sequence of events as viewed in the Minister of Health's Reports. The 1945 Report stated that considerable progress had been made, notably at Leeds, Liverpool, and Manchester.

In the 1946 Report we read about the £100,000 gift from the Nuffield Trustees to Manchester University for a special research institute, with the hope that the gift would facilitate a regional scheme under a whole-time director. Some advance was made at Liverpool; Leeds and Harrogate got together, as did also Bristol and Bath. The establishment of the British Legion Rheumatism Unit under Dr. C. B. Heald at Arlesley showed how valuable a public-spirited venture could become under a regional scheme. The Minister lamented the shortage of doctors, nurses, and physiotherapists which slowed down the establishment of adequate facilities in the rheumatism field.

The 1947 Report referred to the difficulty of setting up a new special department for both in- and out-patients at all undergraduate teaching hospitals. All the same, the Royal Free Hospital Unit, under Dr. Ernest Fletcher, and the older Unit under Dr. Copeman at the West London Hospital, both received merited praise and showed what can be done, given energy and leadership. Dr. Kellgren at Manchester and Dr. Sanderson at Liverpool shared this commendation. Leeds with Harrogate, under Professor Hartfall and Dr. Leman, and the Bristol area with Bath, under Dr. George Kersley, were forging ahead. The Minister's Report begins to envisage the development of rheumatism as a specialty, in the interest of patient and doctor alike.

The 1948 Report chronicled some further progress in the units already referred to, but left the main line of advance much where it was.

The 1949 Report added nothing more on the lines of my present enquiry. Not unexpectedly cortisone and ACTH blaze their trail across the pages, and when the glare has subsided we read the sober reminder that:

the problem presented by the rheumatic group of diseases still remains a formidable challenge to medical research and no opportunity should be missed of providing those qualified to tackle it with the facilities necessary for its investigation.

The 1950 Report listed still another rheumatism Centre, namely, that at Sheffield, under the joint management of the United Sheffield Hospitals, the Regional Hospital Board, and Sheffield University.

By the courtesy of Dr. Conybeare I have been given a preview of the material which will form the basis of the rheumatism section of the Minister of Health's Report for 1951. The London groups are now closely associated with the general medical departments of their respective teaching hospitals. The Leeds-Harrogate effort is being reorganized. Sheffield is quoted as a good example of the co-operation of a university, a teaching hospital, and a Regional Hospital Board. Bath is entirely dependent upon the South Western Regional Hospital Board. So much for the Minister's reports.

In 1950 the Royal College of Physicians set up an important committee to consider the organization of the treatment of chronic rheumatic disease with reference to the needs of the National Health Service. In the committee's report, the setting up of special centres is once more recommended, and stress is laid once more upon the need to link these with the medical departments of general hospitals which are schools of a university. Consideration is not given to secondary centres. The question of specialization is discussed; the Committee thinks that rheumatic diseases should not generally be a whole-time specialty but should constitute a special interest within general medicine.

Finally, it has been my privilege to read the replies from the Regional Representatives of the Empire Rheumatism Council to a questionnaire on the rheumatism facilities in their regions.

What is the general impression left in my mind after perusing all these sources of information? I try to make an objective and balanced assessment of the position. Here and there I see an approach to implementing our plan which earns my warmest approval. This is, of course, how we British get things done, in single file, not in battalions. But I am bound to confess that the general advance seems to me to have a somewhat ragged front. Why? Are we possibly too academic in our attack upon this problem? Is there an inhibiting influence born of a fear that we may upset the neat and traditional schema of the student's curriculum and the sanctity of the syllabus?

I remember that Dr. Conybeare, in an address on the medical care of chronic rheumatic disease in England under the National Health Service, which he gave in New York at the recent International Congress on Rheumatic Diseases, said:

The present reluctance of the medical staffs of a majority of the English teaching hospitals, and in par-

ticular of their specialist physicians, to accept Rheumatology as a diagnostic and therapeutic specialty . . . may be regarded as the chief administrative difficulty in developing better medical care for rheumatic patients under the British National Health Service.

If that be so, and I am not prepared to deny it, let us examine the position and if, Ulysses-like, our purpose still holds, let us do something about it.

"Rheumatic disease a specialty within general medicine?"

Why not? We bow the knee to cardiology, to neurology, to psychiatry—to other-ologies "within general medicine". Must we, once more, repeat the dismal recital of the toll of pain, of disablement, and of economic wastage due to rheumatic disease, and point out the need for research, coupled with careful clinical appraisal of the individual case, and so start this campaign all over again?

A number of factors combine to make the present time ripe for another forward move. New lines of research in the chemical and histological parts of the rheumatism field are highly encouraging and suggestive. We have seen the terrific impact of the cortisone adventure upon our ideas of aetiological reactions on the systemic side of rheumatic processes. There have been rapid, not to say phenomenal, developments in physical medicine during the past two decades.

All these things indicate to me so clearly that, in a wide and intensive study of the rheumatic diseases, the current serves us now, and that if we do not take it we may well lose our venture.

Am I impatient? Do you say, "give the thing time"? I can only plead, in extenuation, that the cliché "it is later than you think" applies more to me than to anyone who compliments me by listening to this address.

There are moments when I feel (to extend Sir Henry Cohen's metaphor) that the Princes of Academic Medicine think it derogatory to take this Cinderella into the dance. I hope I am wrong, but if I am right, here is a situation which needs examining. I plead for the rheumatic patient, and I plead with conviction because I have found, in a long experience, that the doctor who knows how to handle a case of chronic rheumatic disease may easily be counted among the best doctors I meet.

It may well be that we shall not get much further with our plan until we up-grade the importance of the rheumatic diseases, up-grade them in our own thoughts and actions and up-grade them in the careers of those much younger men and women who are coming after us.