RHEUMATOLOGY, PHYSICAL MEDICINE and the FAMILY DOCTOR

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THAT the term ' rheumatism ' survives at all in an age of scientific scepticism is testimony to its convenience in denoting painful conditions apparently arising from moving parts of the body, usually for no obvious reason. Such conditions are relatively common.

In recent years there have developed two separate, though interrelated, hospital disciplines each concerned with medical diseases of the locomotor system. One of the inevitable results of specialization is the difference in the pattern of disease seen in the discipline and that seen in general practice. This is a brief record of impressions gained by a family doctor, with an interest in rheumatic diseases, after visiting several rheumatic units and physical medicine departments.

Patterns of disease

Despite difficulties with definitions, several surveys have suggested that, in general practice, the various diseases of the locomotor system occupy about 6–7 per cent of the whole spectrum of disease. The Morbidity Statistics Survey conducted by the College (1958) shows that ' arthritis and rheumatism, except rheumatic fever ' gave rise to a patient consulting rate of 64.9 per 1,000 during the year and came second to acute nasopharyngitis in the order of prevalence rates of the various conditions. A condensation of the pattern seen during the Survey is shown in figure 1. Thus, for the family doctor three quarters of what might be called ' rheumatism' consists of a variety of painful states nearly all ' non-articular '.

The rheumatic unit, however, sees a different sort of picture, and one which was remarkably uniform for the units visited. This pattern is shown in figure 2, based on material provided by Duthie (1965). At least two-thirds of the rheumatological conditions encountered are ' articular ', and of the remaining third only a relatively small fraction (about 6 per cent of the total) is ' non-articular '.

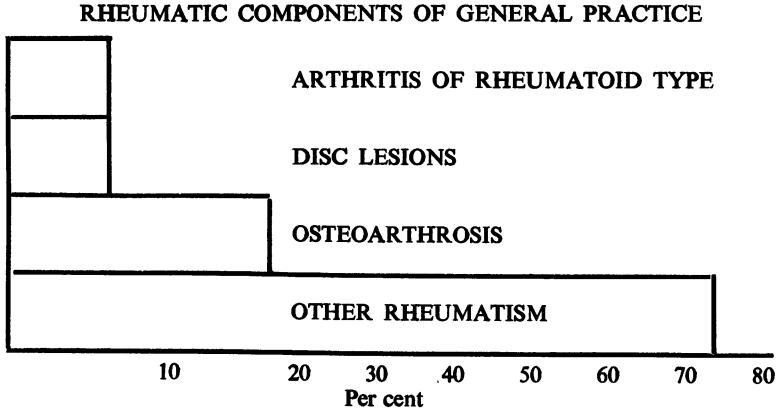

Figure 1.
Pattern of disease

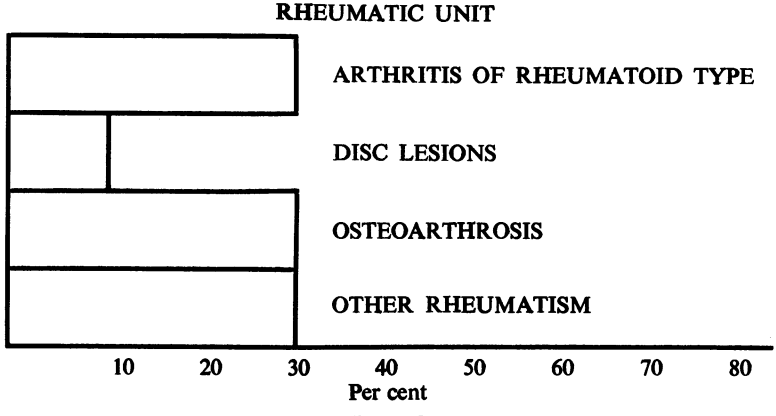

Figure 2.
Pattern of disease

A small, but for the general practitioner significant fraction, is composed of general medical conditions masquerading as rheumatism—myxoedema, leukaemia, malabsorption syndrome, carcinoma, etc.

The physical medicine department sees a slightly different pattern still, shown in figure 3. Here the main component is a very mixed bag, containing a much larger proportion of ' non-articular rheumatism ' and general medical conditions than the rheumatic unit. Interestingly enough, the proportion of disc lesions remains remarkably constant for all three types of doctor.

Approach to diagnosis and therapy

One of the main functions of the family doctor is the sorting out

of previously unselected clinical material. The lack of clear definition of even some of the better known rheumatological states, and the evanescence of the rheumatism encountered in general practice make the task more difficult. The label ' fibrositis ' is too convenient, and it is not easy to maintain a critical attitude to diagnosis.

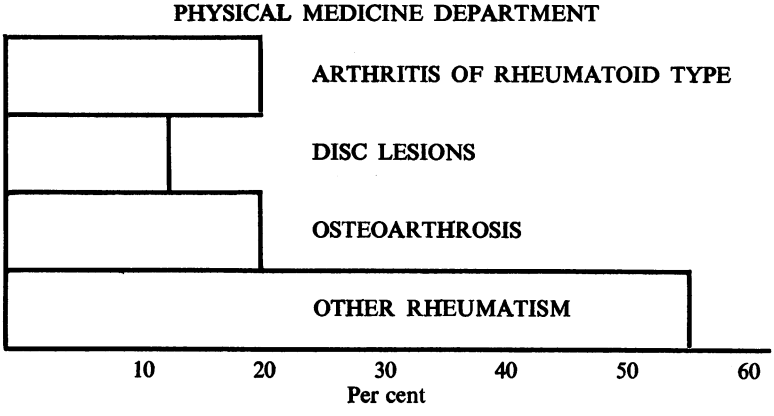

Figure 3.
Pattern of disease

It was one of the characteristics of the rheumatic unit that it was preoccupied with this problem, almost, it seemed on occasion, to the exclusion of therapy, since one hospital visited offered only a diagnostic service with outpatient follow-up having virtually no beds. While it was difficult to assess the proportion of patients coming to the units from different sources, it seemed that up to about one-third might be referred from other hospital departments for an opinion—a further comment on the difficulty of diagnosis even when full facilities are available.

On the other hand, the physical medicine departments visited seemed far less concerned with the diagnosis of disease as such. Indeed, many of their patients had been referred with morbid processes already accurately diagnosed—hemiplegia, poliomyelitis, perarthritis of shoulder and so on. The chief aim was rehabilitation, and diagnosis was directed not so much to the disease process as to its exact effect on function. Much use was made of electrical aids, such as the electromyograph and equipment for the study of nerve conduction, and intensity-duration curves.

Both disciplines were most concerned to help their chronic disabled patients, and it was of interest to see the remarkable efforts made by certain units to assist such patients achieve maximum independence. The ' Daily Activities ' unit of King's College Hospital, where the occupational/physiotherapy department con-

tains virtually a complete house, deserves special mention. However, it seemed that the patient was often in danger of becoming ' clinic dependent ', and discussion with physiotherapists and occupational therapists clearly showed that they occasionally fulfilled the role which would otherwise be filled by the family doctor.

In one rheumatic unit case conference, discussion centred on a lady on long-term steroid therapy. Having run out of supplies, she decided to forego her drug, because she did not like to attend the clinic before her appointed time, and she had lost touch with her family doctor. As a result she became very ill.

It is not suggested that this occurs commonly, but it illustrated the dangers of ' dual care '.

Rehabilitation

The protracted attendance at hospital may defeat the ultimate purpose of helping to restore the patient. It was stimulating, therefore, to see something of the activities of the London Rehabilitation Centre, where the accent was on such concepts as active exercises, group therapy, encouragement and maintenance of high morale, and all this outside a hospital atmosphere where the patient does not automatically feel that his relationship to others is one of *dependance*. So keen was the desire to rehabilitate the patient as fully as possible and to reduce further contact with doctors to a minimum, that the centre often discharged the patient on a Friday already furnished with the final certificate to start work on the following Monday! If once again the family doctor was being by-passed at least this time it made sense.

A similar ' non-hospital ' atmosphere was achieved at the well-known Royal Air Force Centre at Chessington, which, in recent years, has opened its gates to civilians in the area. Surprising as it may seem, this mixture of Service and non-Service patients works extremely well. The civilian undoubtedly benefits from the atmosphere of Service discipline and high morale, while the Serviceman is none the worse for contact with the ' outside world '.

In both these centres, the ' remedial gymnast '—a cross between the Service P.T. Instructor and the civilian physiotherapist—was encountered for the first time. Such a medical ancillary plays an important role in this type of centre, for which there seems to be a need in the National Health Service.

Manipulation

This account of services available to sufferers from diseases of the locomotor system would be even less complete without brief mention of manipulation—a controversial aspect of therapy undoubtedly neglected by the profession to the possible detriment of the patient but benefit of the untutored cheiropracteur.

A visit to the physical medicine department of St Thomas's Hospital found Dr Cyriax conducting a review of his failures—something which more of us might do. Although the techniques could readily be acquired, I felt that their application to problems in general practice was limited by the necessity for x-ray examination in each case. The technique of epidural injection was demonstrated, and this seemed a useful therapeutic (and diagnostic) procedure, which could find a place in the well-equipped group practice. Batirerega *et al.* (1965) have recently assessed the place of the technique, and comment favourably.

Research

The difference in accent between the rheumatic unit and the physical medicine department was illustrated in the attitudes to research. While it seems that the physical medicine department were preoccupied with providing, in the main, a therapeutic service, research projects were not greatly in evidence. Each rheumatic unit, however, had a programme of research. Several were engrossed in attempting to evaluate various drugs, a ploy which was described by one worker as ' akin to the task of Sisyphus '.

Summary

It seemed to me that in the rivalries between the two disciplines there is a danger of perpetuating a false antithesis between the diagnostic orientation of the rheumatic unit and the therapeutic function of the physical medicine department to the detriment of each, and more important—to the patient.

There might be a closer degree of co-operation between the two hospital disciplines, and a much greater effort is needed by all concerned to integrate the family doctor with the existing facilities for sufferers from diseases of the locomotor system.

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