

**SECOND SESSION****Rheumatology in general practice**

**Dr J. H. Hunt**, M.A., D.M., P.R.C.G.P., F.R.C.P., F.R.C.S., F.A.C.G.P. (*Chairman*)

I WAS impressed by what Mr Kates told us this morning about the surgery of rheumatoid arthritis. It gives us all a great deal of encouragement that so much can be done to help these people. I was interested in what he said about the position of the general practitioner in all this. He put us at the beginning and the end of the case but I think we ought to be there all the way through. There is a tendency to call the general practitioner the 'doctor of first contact', but I am sure 'doctor of continuing contact' is a far better term.

There are 60 subjects of special interest which the general practitioner can study; about half of them are clinical and rheumatology is certainly one of the most important.

The recent Royal Commission's Report gives a boost to our post-graduate vocational training. It says quite clearly all the way through that general practitioners and specialists should be equal; but general practitioner is spelt throughout with a small 'g' while consultant always has a capital 'C'!

Dr Dudley Hart mentioned 'the Zulu's advice' but he did not tell us what it was, I asked him at lunch time and he said "An old Zulu of 82 with grey hair and as fit as a fiddle was asked to what he attributed his longevity and his health, to which he replied that he had learnt always to co-operate with the inevitable". This is what patients with rheumatological conditions so often have to do.

This afternoon, we are to talk about social problems and the management of arthritis; our session is introduced by Dr Barbara Ansell, followed by members of our sister professions. I do not like to call them ancillary workers or paramedical workers; I think 'sister professions' is a much better term.

**Social problems**

**Dr Barbara M. Ansell**, M.B., Ch.B., F.R.C.P. (*Consultant physician, Rheumatism Research Unit, Canadian Red Cross Memorial Hospital, Taplow, Maidenhead, Berks*)

RHEUMATOID arthritis is a relatively common disease which is lived largely at home. In its mildest form it causes little interference with normal life although the patient may be unable to participate in sport, while in its most severe form it can render a person housebound, chairbound or even bedfast. Social problems are encountered

and depend on factors such as the age of the patient, the severity of the disease process, available help, individual understanding and intelligence. The financial background of the person afflicted can be very important.

With arthritis in childhood the parents will need help and advice to enable them to give the child the necessary reassurance without over-protecting him or her. Necessary adjustments within the family circle will require supervision, both when the child is in hospital, and when he is discharged. Visiting is of great importance to a child who has long periods of hospitalization and this may need financial aid. If a stay is likely to be protracted, we encourage parents to have a child home for a day or a weekend as frequently as possible. Regular letters often help to ease the feeling of separation and parents particularly appreciate hearing from their children.

Prior to discharge arrangements for their further education should be made. Under the Education Act of 1944 all children should be educated according to their age, ability and aptitude. Although many services are available through the school medical officer, whenever possible for children with Still's disease a normal school environment should be provided. Many of the modern schools of today are built on one floor, with easy access to buildings, and are ideal for children with some limitation of lower limb function; persuasion may be required to ensure their acceptance. Transport to school is often another problem; it is usually possible for the school medical service to provide a special bus, or sometimes a taxi service for an individual child.

Admission to any special school is of course on the recommendation of the principal school medical officer of the county council concerned and both general practitioners and hospital doctors may make their recommendations to him. The decision as to what type of school a child should go to may be extremely difficult; much too frequently the background of the family is not taken sufficiently into account. For instance, it might be better for a child from a broken home to go to a residential school for the handicapped, where regular physiotherapy is obtainable as part of the curriculum; a similar or even more severely handicapped child could manage perfectly well in a home with a stable background where exercises could be done under parental supervision, and medications given at the right times, and splints used in the right way.

With patients above 16-years old the question of suitable training for work or placement in jobs arises. Up to the age of 18 the services of the youth employment officer are required, and afterwards the advice of the disablement resettlement officer who can arrange for admission to a government training centre or to a training college, or find suitable employment. The range of help required in this age group varies enormously. At one end of the scale it may be necessary to try and help a severely handicapped young man or woman, mentally equipped to enter a university, while at the other end of the scale, one may be called on to recommend admission to sheltered industries which provide opportunities for residential employment such as the Yately Craft industry or the Bookham School of Stitchery and Lace.

In adult life, the woman should be able to run her own home and, to help her to do this, assessment in an occupational therapy department or a visit from a domiciliary occupational therapy unit will often be required. She may need training to perform usual tasks more easily; she may need house modifications or even transfer to more suitable accommodation all on one level.

Just as over-protection in the child does not allow independence to develop, so the middle-aged woman who is constantly looked after by her family loses all incentive to run the home, and it is important that she is encouraged to tackle as many jobs about the home as possible. With the man, the questions of suitable employment and ease of travel to and from work have to be considered. It is always easier to retrain a person earlier than later in life and advice on vocational retraining frequently has to be sought

either through rehabilitation units or direct approach to the disablement resettlement officer. The elderly patients pose even more problems. Many who are temporarily rendered bedfast by intercurrent illness will not try to help themselves in rehabilitation, saying that they are too old to learn new ways of doing things. If they have no relatives, residential accommodation should be found. However, there are some older patients, particularly when helped by willing families, who will attempt to regain independence and will be able to return either to their own home, or to a modified home. Whilst welfare services can arrange modifications, the patients who are able to finance these for themselves, have a great advantage over those who cannot: the luxury of a small greenhouse for a keen gardener may make all the difference to his outlook. The whole problem of motivation of patients with chronic disease is one that has not yet been sorted out and while young people are usually willing to help themselves, this is not necessarily so with the middle-aged and older people. They tend to rely on members of the medical and ancillary staff for their motivation, and it is important that doctors realize this.

In order to be able to help and direct activity of a handicapped person, assessment is extremely important, and in assessing patients various things must be considered. First come the necessities of daily life. It is important to be able to dress unaided, even if clothes have to be modified to do this. It is important to be able to go to the toilet, wash, and bath without having to ask for help, and to sit down with the family at meals. The mother and housewife should be able to run her home. This includes cleaning and preparation of food, and clearing away of meals; while good friends of the family and neighbours are ready and willing to shop, it is somehow not the same as making the selection oneself.

For many disabled patients a car is a necessity if that person is to be able to lead a reasonable normal life, go to their work, and shop and so on. The Ministry of Health regulations provide transport if, after suitable assessment, it is considered necessary. Many patients with rheumatoid arthritis can manage an electric three-wheeler where they could never manage a proper car, and three-wheelers are much easier to modify for individual needs. The disadvantage is that the patient has to travel alone. If a person is eligible for a Ministry of Health car and wishes to run an ordinary car, a certain amount of money is provided for conversion. However, he does not usually receive free petrol, garage and insurance, as he would if he accepted their three-wheeler, particularly if he is not the sole driver of the car. Modifications to an ordinary car may need to be quite extensive and it needs a reasonably intelligent person to get the best done. The government grant does not, of necessity, completely cover essential modifications to an ordinary car (*e.g.* recently £90 was given and £140 spent). In addition to basic changes, a helpful garage and a competent driver may be able to work out between them useful minor alterations. These might include a lever for starting the engine instead of a key, the elongation of a gear lever or a door handle, or the fitting of a wider driving mirror to avoid excessive turning.

When the patient has become reasonably independent as regards dressing, travelling and working, social activities need to be considered. For those who have difficulty in going up and down stairs, it is advisable before visiting friends to check whether there is a toilet on ground level; if not, some form of portable urinal is advisable, otherwise patients tend to cut down their fluid intake for the whole of the day before they go out. Patients who need a higher seat may find a foam rubber cushion useful to take around with them. Before attempting to go to a theatre or a cinema, it is advisable for those people who have difficulty with steps and stairs, to check how many they will have to negotiate and whether there is an alternative entrance. Similarly in shopping patients should use shops with lifts or find out where are the things they wish to buy; time and time again, particularly in the larger department stores, patients tell me what great help they have received when they have 'phoned to make enquiries of this sort. I would

strongly recommend not only to rheumatoid arthritics but to any seriously disabled person the book *London for the disabled* by Freda Bruce Lockhart, who herself has multiple sclerosis.

For holidays, too, the choice of accommodation is important. Airlines and British Railways are most helpful in providing wheelchairs for easy access. If there are many changes to make, with British Railways it occasionally pays to go through the ambulance services.

The more intelligent and financially independent patients are the most likely to be able to use their leisure in the way they like best. If money is short, how does one get the help that is needed? The initial approach can be direct from the hospital, or could equally well be made through the patient's general practitioner. The availability of services varies. Welfare departments are responsible for many things; they must keep registers of handicapped people, employ welfare officers to advise, and give a certain amount of help, but services may differ from one area to the next. For instance in some areas there is a neighbourly help service in which neighbours are paid a certain amount per job, as well as the home help service. The Consumers' Guide to the British Social Services is valuable for reasonably intelligent patients, if they want to see what social services are available. Many of the regulations are permissive; authorities *may* provide assistance to handicapped persons in their home; they *may* provide centres for recreation and occupation, or a sheltered workshop; or home employment schemes, or holidays. Essential accommodation *must* be provided for people who, because of age, infirmity or chronic illness, are in need of care and attention but who do not need hospital accommodation. However, there are usually extremely long waiting lists.

In addition to the local welfare services there are many voluntary services that help a great deal. The W.R.V.S. often with a grant from the local authorities, provides meals on wheels, and the British Red Cross does an enormous amount of work for the welfare of the handicapped and the elderly. For older patients the old people's welfare committees and the National Old People's Welfare Council are valuable as general sources of information. One of the great problems with older patients is loneliness. They cannot get out and lose touch with their friends. Here the voluntary organizations, in arranging visits and good neighbour services, are invaluable.

Despite the tendency for many patients with rheumatoid arthritis to develop changes which make modifications of their way of life inevitable, particularly in the younger age groups, many can achieve personal independence. The ability of these people to participate in society depends on a combination of intelligence, which is extremely important in vocational rehabilitation, and the facilities that can be made available to that particular patient. Older patients find much more difficulty in adapting to their changed circumstances.

Suitable reading material for patients: *Your home and your rheumatism* and *Your garden and your rheumatism*, published by the Arthritis and Rheumatism Council. Price 1s. 6d.