I suspect that many rheumatologists in the UK are unaware that the origins of our speciality were closely bound up with government schemes to improve employment opportunities. The Second World War left behind injured servicemen and women and civilians; repairing both physical and mental damage was a priority. Large numbers of injured and unemployed workers needed assistance at a time when labour was required to rebuild the country and start to repay the nation’s debt. Experience in the services had shown that active rehabilitation could greatly increase the chances of achieving full employment after injury [1].

Departments of physical medicine were set up in general hospitals or attached to regional orthopaedic centres, to find answers and co-ordinate rehabilitation services [2–5] and employment rehabilitation units were built [6]. Initial finance came not just from the health department, but also from employment services, works departments and heavy industry. Much expertise came from the services: many of our leading lights in the 1950s, 1960s and 1970s originally held service appointments.

In those formative years, the stock in trade were young adults with industrial or military injuries. Resettlement, retraining and alternative employment opportunities with assistance from employment resettlement officers in addition to the arcane crafts of the physiotherapist, remedial gymnast, occupational therapist, orthotist and psychologist resulted in multi-specialist ward rounds, requiring a very different approach to medicine. Being aware that the origins of our speciality were closely bound up with government schemes to improve employment opportunities as the 1970s became the 1980s, the customers for resettlement and rehabilitation changed. Advances in orthopaedic surgery and the disappearance of infectious disease left a population of multiply handicapped children and older adults. Patients requiring employment advice—young adults post-illness or trauma—appeared to be a diminishing resource. Specialist training programmes turned to rheumatology in medicine, new sciences changed the outlook entirely and rehabilitation became concerned with the multiply handicapped and the elderly [9, 10].

During the 1960s, it became apparent that advances in social and financial support for the sick and unemployed were having unexpected consequences. Far from enabling the injured to return to work more quickly, the opposite was occurring. Time off work for a common, standard injury (Pott’s fracture of the ankle, for example) was getting longer. A re-examination of the relationship between impairment, disability and handicap was required. Rodney Grahame discussed these interlinked facts 30 years later, observing that the decline in rehabilitation services might be related to financial disadvantage for the disabled unemployed [11]. He also observed that by omission we had lost an important subspecialty group [12].

The majority of illnesses and injuries causing time lost from work nowadays are not complex cases with profound physical and mental pathologies; they are modest physical problems, and the demise of the physical medicine specialist has robbed us of a resource to observe these problems and teach their intricacies to younger doctors.

My rehabilitation training in the 1970s was peppered by the word expectations. Patients’ and doctors’ expectations of illness and injury were becoming very different. The interaction between illness and time lost from work is
complex, as are the reasons for those expectations. My personal feeling is that our failure to educate the broader medical church about the realities of common rheumatic problems is partly to blame. The wider population’s belief about the consequences of back pain would amaze many. Yet another subject for the overcrowded undergraduate curriculum?

Return to work has not been used as an effective measure of treatment or rehabilitation because so many non-medical factors are involved. As medical specialists, we approach this as a simple progression through injury/illness/loss of work/diagnosis/successful treatment/return to work—this is appropriate to our middle-class, white-collar, work ethic-driven lifestyle. Few of these constructs are considered relevant by a large proportion of the population.

Buchbinder et al. [13] ably explained this by demonstrating the power of the popular media in reducing time lost from work, and the level of financial compensation, from low back pain. Observing the success of the ‘Slip, Slap, Slop’ campaign in the Australian press raising awareness about skin cancer, they showed that an approach through the popular media could work on doctors as well as patients and that the effect was maintained over time. Remember that these thoughts come from Australia, home of Repetitive Strain Injury, the greatest non-disease of all time. Recognize that the fact of return to work from illness and injury has little to do with rheumatic pathologies and more to do with popular belief than with health professionals. Let us then return to our roots and consider centrally our patients’ employment potential; but let us not forget that diagnosis and treatment are but a minor part of the return to work process.

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