THE EMPLOYMENT OF THE RHEUMATOID ARTHRITIC*

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The rheumatoid type of arthritis is one of the most variable disorders encountered in medical practice. Unfortunately those cases which run a long, painful, and crippling course have so influenced doctors, social workers, employers, and the public that many of them tend to take an unduly pessimistic view of the employment prospects in this disease. It is forgotten that rheumatoid arthritis often causes little disability. Many patients continue to work throughout their illness; others return to their own or more suitable jobs after a few weeks or months; and only a minority are unable to work for a prolonged period.

Course of Rheumatoid Arthritis

The disease cannot be divided into clear-cut stages, but it is helpful if early and late cases are considered separately. The early stages are characterized by active inflammation, but this is often mild, and many patients continue at work, while some even fail to consult their doctor. When the activity is more severe work may be impossible, but this depends as much on the nature of the job as on the severity of the disease. Unexpected exacerbations and remissions are common and make prognosis extremely difficult.

After a variable period of months or years the inflammation usually subsides and function improves as a result. Although there may be some superadded fluctuation in joint activity from time to time, the arthritis is now more stable and predictable. The permanent deformities and degenerative changes usually increase slowly, but their extent is very variable. Often they are not severe. Kellgren, Lawrence, and Aitken-Swan (1953), in a field survey, found that half of the rheumatoid arthritics in a population sample had lost no working time for five years.

Medical Responsibility for Employment Problems

Rheumatoid arthritis is an unstable disorder in sharp contrast to stable disabilities such as the loss of a limb, blindness, or residual paralysis after poliomyelitis. In the stable disabilities it is usually possible to conclude treatment and medical rehabilitation. Then welfare and employment officers can take the responsibility for resettlement into suitable living and working conditions with only limited medical guidance.

In rheumatoid arthritis finality is seldom reached in the treatment, rehabilitation, or resettlement of a difficult case. Furthermore, assessment for work is largely a medical matter requiring clinical examination and an understanding of the potential function and prognosis in each patient. With difficult employment problems it is never enough to fill in a reference form and leave the rest to lay personnel. The physician must take an active interest himself and co-operate with employers, personnel managers, and employment officials at all stages to ensure that his patient is guided into suitable work.

Resettlement Conferences

At King's College Hospital resettlement conferences have been held regularly for several years. These are designed to assist the resettlement of patients with disabilities of many

kinds and have proved particularly helpful for rheumatoid arthritics. They are attended by the physician, the disablement resettlement officer (D.R.O.) from the local employment exchange, the almoner, the occupational therapist, the physiotherapist, and the patients. These conferences have been an education to all concerned and have created a very helpful liaison with the D.R.O. He is essential, for he knows what work is available, what it involves, and whether the patient's training and ability are adequate.

Results are not as good when patients come from other districts where direct liaison with the D.R.O. is lacking. This is not the fault of the D.R.O., for he cannot be expected to appreciate all the medical aspects of an individual case, and the standard form is no substitute for direct discussion. Under such circumstances better results are sometimes obtained if the almoner makes direct contact with employers who are known to be co-operative.

Management of Rheumatoid Arthritis in the Early Stage

From the start patients must be helped to understand their disease and how to live with it. In particular it is important to allay the great fear so often experienced, but not always expressed, of being crippled and unable to work or to undertake household duties. It is also necessary to make clear to patients the limitations imposed by their disease. All too often they persist in an unjustified belief that they will eventually return to their original work. This may keep them unemployed long after they are capable of doing more sedentary work without difficulty. Indeed, it is too much to expect that they will make the decision to change their work without a full understanding of their disease and its implications. For instance, to obtain employment a disabled farm-worker may need to take his family to a neighbouring town where light engineering work is available. Without a full explanation from the doctor he may stay on in the country indefinitely, hoping for an impossible measure of recovery.

It is also wise to consider a patient's employment at the earliest opportunity. This should not be left until the active phase has subsided. Apart from saving time, the doctor's interest in return to work is good for morale.

The patient's customary work must be taken into account from the outset, and it is a fortunate circumstance when it is of a sedentary nature. If the work involves heavy manual labour or much walking or climbing, the patient will have to change to more suitable work sooner or later. Unless there is early recovery he should be advised to accept the necessity to change his work, and plans should be made for resettlement as soon as possible. Labourers in heavy industry and the building trades are a particular problem, for usually they have attained only a low educational standard. When their disability enforces a change of occupation it is always difficult to find alternative jobs, as most of them are suitable only for unskilled manual work.

The change from moderate activity to still lighter work may be necessary, but this is never an easy decision to take. Two factors need to be considered. Reduced physical activity usually favours the joints. On the other hand, change of employment often involves less skilled work and lower wages, except for young patients who are able to undertake a full course of vocational training. Sometimes it is best to temporize and advise sedentary employment well within the patient's physical capacity until the joint activity has subsided. This is certainly better than no employment at all and does not prevent the patient from obtaining more suitable and highly paid work when his condition improves.

A period of rest from work is sometimes advisable. Whether to insist on rest or to allow patients to continue at work is a difficult decision which may have to be taken several times in the course of the disease. General rest and local rest for the affected joints are probably the most effective forms of therapy at any stage. On the other hand, patients who are busily occupied in work within their physical capacity are often less conscious of pain and less apprehensive about their disability than those who are off work and have little to do beyond attending hospitals for

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physiotherapy. Therefore physicians will often have to resolve the anomaly that rest is best for the joints whilst work is an effective analgesic and good for morale.

When patients have been off work for a long time it is not easy to judge whether they are fit to resume. It is a long step from rest and physiotherapy to a full day under industrial conditions. The modern hospital occupational therapy department, incorporating industrial work, is invaluable in the management of rheumatoid arthritis, since it provides for the graduated restoration of function up to a full day at the bench. Thus doctor and patient can satisfy themselves that the type of work found under industrial conditions can be undertaken without undue difficulty or detriment. They can also reach some estimate of the work that most suits the patient's residual physical capacity.

A further advantage of occupational therapy is that patients remain under the observation of their own physicians, whereas in the industrial rehabilitation units the decision concerning their industrial future is taken in a few weeks by doctors and other personnel who have not the same advantage of knowing them and their reaction to the disease.

Management of Burnt-out Rheumatoid Arthritis

Sooner or later rheumatoid arthritis appears to have run its course. In some the disease may resolve, leaving no apparent disability and minimal changes. Physical recovery may be so complete that no more is necessary for re-employment than the patient's full realization that he is no longer disabled.

Other patients need more help. Function always improves when the joint activity and pain are less, but full restoration of function may require progressive activity in physiotherapy and occupational therapy departments. Progress is often slow, and for the best results patients may need to attend all day five days a week. Treatment lasting an hour or so two or three times a week is inadequate when the disability is severe, except perhaps for a few patients of character and determination who would probably do as well by their own unaided efforts.

A small minority of patients are crippled with severe deformity and restriction of joint movement. These are the classical cases of burnt-out rheumatoid arthritis, many of whom have long been classed as incurable and relegated to institutions for the chronic sick, or to the care of relatives and local welfare organizations. One of the advances in recent years has been the recognition that many of these patients can be rehabilitated to a surprising extent. This applies more especially if there has been continuous care throughout the active stage of the disease instead of abandoning all efforts when extensive disease appears to be worsening in spite of therapy. The restoration of function should be directed in the first instance to helping these patients to regain independence of attendants and relatives in the activities of daily living, such as toilet, dressing, feeding, and moving about. Partial independence is all that some patients can achieve. Those who regain full independence should continue treatment with a view to work at home, in sheltered employment, or in open industry, depending on the progress made.

Use of Aids and Appliances

The timely use of splints and other appliances to prevent deformity and relieve strain on painful joints can do a lot to assist functional activity and return to work. Examples are surgical shoes with built-in arch-supports and valgus stiffening, outside irons with inside T straps to prevent valgus strain at the ankle, knee- and elbow-cages, and moulded leather or plastic wrist-supports.

At work employers can help by allowing benches, tables, stools, and chairs to be altered in height to suit individuals, and larger operating handles or grips to be fixed on industrial tools. These are all relatively inexpensive modifications which can make all the difference to industrial efficiency.

Evening Clinics

Many patients with rheumatoid arthritis may need physiotherapy to relieve pain and prevent deformity even though they are otherwise fit to work. At present far too many patients are missing work, or are off work entirely, in order to attend physiotherapy departments two or three times a week in the day-time. This practice cannot be condemned too strongly. Unavoidable loss of work puts enough strain on the patient's resources, and physiotherapy can easily be provided in evening clinics.

Transport

The means of travel to work may be as much a problem as the work itself and needs consideration at an early stage. Some patients are able to use public transport if they can take their time, but cannot manage in the rush hours. In large cities it is often possible to find suitable work at the periphery so that they travel in the opposite direction to the crowds.

Invalid motor-tricycles were primarily designed for hand-control by patients with disabled legs, but in recent times more attention has been given to the needs of patients with disability in all limbs. Patients with severe rheumatoid arthritis are still at a disadvantage because steering and applying the brakes require free arm movement and a good grip.

Sometimes the application of a patient with rheumatoid arthritis for a motor-tricycle is turned down. It is useful to remember that continuous activity in the occupational therapy department has brought these patients to the stage of being considered suitable for work. The same principle may be applied to their driving. If a motor-tricycle can be borrowed and patients given the opportunity to practise off the public highway, they may well persuade the authorities that they can control a suitable machine. If so, the greatest hurdle between severely disabled patients and their work will have been surmounted.

Patient's Determination to Work

So far little mention has been made of the patient's personality and determination to work, which inevitably are vital factors. Sometimes enthusiasm can be restored in a dispirited patient, but more often it is the patient's own personality that demands independence and usefulness. Without this spirit work may be an impossible goal, and with it all the resources of modern rehabilitation may be redundant.

Summary

Most rheumatoid arthritics can do regular work.

If the customary work is unsuitable, the physician must play an important part in guiding the patient into suitable employment. Co-operation with the employment officials is essential.

In the active stage plans for work must be arranged as soon as possible, and the patient must be helped to understand his disease and its effect on employment prospects.

Physiotherapy and occupational therapy may be useful in restoring function and for assessing a patient's ability to work.

Sometimes severely crippled patients can be restored to work in open industry.

Transport from home to work may be a more difficult problem than the work itself.

Employers can assist by allowing minor alterations in equipment.

The patient's own personality and determination are probably the most important factors in securing regular work.

REFERENCE

- Kellgren, J. H., Lawrence, J. S., and Aitken-Swan, J. (1953). *Ann. rheum. Dis.*, 12, 5.