Personal View

Mrs A is 58 and looks old for her years. She has a 40-degree loss of extension of her knees and there is a pronounced valgus deformity, worsened when she stands. Radiographs show extensive retrogressive remoulding of the lateral tables of the tibiae. She has been housebound for two years and is now practically roombound. She has been on the orthopaedic waiting list for a knee replacement for 14 months and has longer to wait yet, as there are many ahead of her with equal or worse disease. Her doctor asked me to see her again the other night to see if I could help further. But how could I? It is not the fault of my orthopaedic colleagues, for they are swamped with such problems and without resources adequate to help. I explained the difficulty as well and as sympathetically as I could but the look in her eyes when she said she knew that I was doing my best made me turn away feeling sick and humiliated because as a profession we are not doing enough for her and thousands like her, and I am ashamed of it.

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I know her problem is not unusual; it can be reduplicated up and down the length of this kingdom. But that does not take away one shred of the humiliation or one peck of the shame. Here we have a National Health Service dedicated to bringing proper care to those who need it where and when they need it, and after 33 years we have singularly failed to plan adequate resources for the disabled almost anywhere you care to name. We have a cadre of planners at the Department of Health, at each regional health authority, and each area or district, but we have yet to relate waiting lists and evident need to resources. We have not done the manpower planning, we have not given the necessary thought and executive action to establish enough resources in terms of theatres, theatre staff, beds, surgeons, and rheumatologists to come anywhere near coping with the obvious need of the community around us and among whom we work.

It is a damning indictment of us all: the medical profession for not insisting on the right resources in the right places; the planners for not looking with some intelligence and drive at the self-evident problems; and the politicians for not having willed the means. God knows, the problems of individual arthritic patients surround us on every side. In every outpatient department, in every street, every shop, at every bus stop and railway station the less afflicted are there plainly to be seen. The worse afflicted cannot so easily be seen, for they are confined in their homes dependent on the goodwill of relatives and neighbours. Yet their problems can be alleviated to a reasonable degree if only we had a fair distribution of the available finances to train and employ enough rheumatologists and orthopaedic surgeons, to build and staff enough operating theatres and beds, and to finance the community services to let them return to their own home in comfort and independence. Yet we spend just 4·5% of the National Health Service budget on the physically disabled. For example, my own region has only five rheumatologists to cope with the locomotor disabled in a population of 3·7 m. Liverpool, Yorkshire, and the West Midlands are no better.

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The answer to these criticisms is always the same—an expression of polite sympathy, a raising of the hands, and a shrug of the shoulders with the apologetic comment that there is no money. An easy answer to shelter behind but it is plainly not true. The money needs reallocating. I know that this is not the only Cinderella of the Service. A recent *BMJ* leader (9 May, p 1500) outlined the shortage of cardiologists, and I am sure that there are others, and this brings me to my central thesis. Let us look hard and critically at where our waiting lists are longest (though where there is no service there cannot be a waiting list) and let us for once look at what needs to be done to put it right. For a start, when building costs rise at 20% to 30% a year we should look to cutting our planning times ruthlessly so that buildings take a great deal less time to build—that should release a few million pounds. Let us look at where we have too many beds in some areas for some specialties and see if those funds can be diverted to where needs are greater. Health Service expenditure in pounds per head varies from £185 per annum in North-east Thames to £136 in Oxford. Surely a little fairer redistribution to areas of deprivation in our services might be found here. Is this not what the Department of Health is supposed to be doing? Why else is it there but to plan for a *proper* distribution of resources according to obvious need and then to take the appropriate executive action? Why does it not do so?

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This may sound naïve but that is not really the fact. The truth is plain to see and, bluntly put, it is that we have failed lamentably in many regards to put resources where they are needed, and we are all to blame. We have a tremendous amount to be proud of in our Health Service, and I for one count myself privileged to work in it, but that does not stop me from getting angry about its deficiencies at times. If we do not recognise them, how are we to help the Mrs As of this world? She, poor woman, is still there confined to her small sitting room, disabled, frustrated, and in continuous pain. And she still has a long wait yet for relief.

As Cowper said,

> "I never fram'd a wish or form'd a plan,
> That flattered me with hopes of earthly bliss,
> But there I laid the scene."

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