The Royal College of Physicians and Oxford Brookes University
Medical Sciences Video Archive MSVA 175

Dr Christopher Wynn Parry in interview with Dr Michael Ashley-Miller
Oxford, 26 January 1998, Part One

MAM Dr Wynn Parry, I think Kit to all your friends…

CWP Yes.

MAM …which I would like to be included upon, thank you very much for coming, essentially to talk about your career but particularly about rehabilitation. And I wonder if we could start just with a bit of background about your family and your education, and then move gently on to your career and rehabilitation. So, do you come from a medical family, or…?

CWP Yes, in a way. My father was actually a High Court judge. Interestingly, he was devilling for Lord Cohen[1] when he was a young man, when his name was Parry – because the family name is Parry – but Cohen took him aside at one stage and said 'Look here, Parry. I think you're a pretty promising fellow but you'll never get anywhere without a double-barrelled name. Can you get yourself a double-barrelled name?' Well the family has a Christian name of Wynn, so he went along and paid his twenty-five quid at Somerset House and became Wynn Parry. And twenty years later he was a High Court judge, so Cohen was absolutely right! But my grandfather, my mother's father was Berkeley Moynihan, Lord Moynihan, the surgeon at Leeds, and it was always understood, so I gather, that I was to go into medicine. And in fact the influence was strong because my father and mother split up when I was four, so I was brought up by the distaff side of the family, but actually my father's father was a, a surgeon who was in North Wales and then went to Glasgow. So there is a strong surgical leaning in the family, which is why I went in to do as a physician, because I certainly wasn't going to compete with these chaps!

MAM Yes, well, a variation away from the tradition.

CWP Yes.

MAM Did you always feel you wanted to do medicine or, you know, it's one thing to say the family...

CWP Yes, I think if you're brought up to, to believe that, you do. I don't, it never occurred to me that I was going to do anything else, but...

MAM Your school was what, prep school?

CWP Yes.

---

[1] Sir Benjamin Arthur Cohen (KC).

MAM And then on to?

CWP To, to Eton.

MAM To Eton.

CWP Yes.

MAM Where it wasn't, if I recall, particularly strong in your day for breeding doctors?

CWP No, indeed not. There was one other in, in the five years that I was there and went into medicine. And indeed my house-master, a very tough, sportsman-like chap who was I suppose you might call a sort of arch-Philistine, he came into my room... One of the good things about Eton was you had your own room right from the start, so you had a certain privacy and you could develop your own interests and things. And he used to come in every night and have some sort of discussion. And one night he came in, and didn't sit down. I thought this is a bad sign, and he looked at me hard and he said 'I understand that you are going into medicine?' And I said 'Yes, that's right.' So he said, after a, a significant pause, 'Old Etonians either go into the 60th Rifles or into the City. Goodnight.' And I believe that attitude persisted for quite a long time but it's changed now. And in fact I'm very happy to say I belong to the Old Etonian Medical Association, which was started by George Bonney, and we are trying to encourage Etonians to go into medicine. And we give them a prize and some of us go down and talk to them, and there is growing interest and there are twenty or thirty...

MAM So you are not rare birds any more?

CWP No, no.

MAM Now, from Eton, where did you go for your training?

CWP I went to Oxford and stayed on at the Radcliffe, and...

MAM Oh I see, so you were at Oxford all the way through?

CWP That's right, yes, yes.

MAM Yes. Any reminiscences of Oxford?

CWP Oh, they were wonderful because of course we were the second intake at the Radcliffe and we had an enormous amount of...

MAM Weight?

CWP Yes. The first lot was people like Charles Fletcher, you know, this great man who started the Tingewick Society, the pantomime. And that I got involved with, and I used to be the producer and a writer and had to take seven or eight parts because half the people had absconded or were unable to get on to the stage through ... excess

imbibing of liquor in order to cope with stage fright and so on! But those were great days. And we used to take off the various members of staff, which could either lead to instant expulsion or to be asked to be their house surgeon, I suppose to protect them from further... But, yes, there were, there were various excitements in those days. Of course the Americans came to Oxford, and the GIs were a strong force there. And so the, the phase of jitterbugging came on and I'm very proud to say that I was the champion jitterbugger of 1943! The competition was held in the Town Hall...

MAM That's a rare accomplishment! Your major award on moving to Oxford. When you, I presume you did ordinary, I say ordinary, house jobs at the Radcliffe?

CWP No, one went actually, I went straight into pharmacology...

MAM You didn't...

CWP ...because JH Burn sort of recruited me, as I'd done fairly well in the pharmacology part of the training, and showed an interest. And he said 'Why don't you come and have a, have a go at pharmacology?'

MAM Did you not do house jobs?

CWP No, not at that stage, no.

MAM Were they...?

CWP Well we did do, we did house jobs of course before qualifying in those days because the war was on and there was a great need for medical students to take actual, actually a part. As you may recall there were, many of the consultants had come back from retirement, you know, in order to staff the hospital. And I remember I did a house job for Ted Maloney[2], a wonderful New Zealand surgeon, and he... I and Harold Ellis – who subsequently had a much more distinguished career as professor of surgery in London – were his first house surgeons, and we worked sometimes when all the casualties were coming through day and night. I remember not seeing my bed for three days and three nights, and loving every minute of it. A wonderful experience. So one did have a lot of experience as a medical student, but no, I didn't do house jobs. I went and worked for a year in, in Burn's department and did some research – a wonderful experience because he insisted that all his young men should write papers, and he taught us how to write papers. And in the year I was there I had three publications out and learnt a great deal about how to conduct research and how to write and made a lot of friends. And it was a marvellous experience.

MAM How long were you in the, that department?

CWP One year.

MAM Just one year?

CWP Just one year.

[2] George Edward Maloney.

MAM And after that?

CWP Then, a friend of mine said that he'd been up to London recently and had met a man called Basil Kiernander, who was the civil consultant to the RAF in physical medicine, as it then was, and was looking for recruits. And I understood that this was rather an exciting new specialty, rehabilitation, and I went up and was interviewed by him. And I thought this sounds rather exciting, and a marvellous antidote to sitting watching little bits of guinea pig intestine going up and down in tubes and smoke drums. All great fun, but I didn't somehow see myself as peering at a smoke drum for the next twenty years. So, I, I thought yes. And also I'd been unable to join the services. Partly because we were reserved, and then I developed a spot of tuberculosis and couldn't join. And I always felt I'd missed out something and, and felt I really would have liked to have, to have joined the services and experienced what other people said was such a rewarding spell. So I joined up. I joined up on a short service commission for four years and then converted it when I realised...

MAM And that was 1948?

CWP '48.

MAM '48. Am, am I right in thinking that rehabilitation medicine really took off at the start of World War Two?

CWP Yes.

MAM Yes. Just before we move to that period, I want to fill in the background. Was there any formalised, if you like, rehabilitation recognised before the forties. Was World War One...?

CWP Not, not in that sense. Of course, if you look back in the records – which I have done because I'm very interested in the history of this – in the Crimean War it's, it's recorded that in clement weather convalescents were marched about. And in 1911, Stanton Woods[3] was appointed the first consultant of physical medicine, at the London Hospital. But this involved physiotherapy and exercises and was, in a way, a sort of rehabilitation package, but much more palliative then as, than it is now. And then of course the spas were very active in the first part of this century – at Harrogate, Buxton, Bath of course. And, I understand that many servicemen were sent to these spas for re-education and for treatment after injuries. And a spa would, a particular spa would be chosen for its particular waters or its ability to provide certain things like exercise or swimming or open air, or whatever. But, I suppose the first chap that really developed this was Robert James(?) because he opened a curative workshop in the basement of the Shepherd's Bush Hospital, and provided work for people to get better – I mean, a true functional occupational therapy. And this was a great success. But, after the war it, it seemed to die out, and as far as I can make out most of the people with chronic illness were treated by the voluntary services, long before the Health Service of course. And it wasn't until the thirties that the physical medicine started to develop. A number of hospitals had facilities for treating people, mostly

[3] Sir Robert Stanton Woods.

with ultraviolet for its tonic effect as well as for skin diseases, and electrotherapy, short-wave diathermy and electrical stimulation, faradic batteries and so on. And these departments were usually run by either skin specialists because of the UVL [ultraviolet light], or radiologists because they were the people who had a lot of electrical apparatus, and therefore it seemed logical that they should take this over. And it wasn't until, I think it was about 1931, that the sections of climatology, balneology and the section of electrotherapy at the Royal Society of Medicine fused and became the section of physical medicine. And there were a growing number of hospitals that had departments of physical medicine, which now were beginning to be looked after by general physicians rather than by a radiologist or skin specialist. But it was Frank Cooksey, who was a very great man indeed, at King's, who really was the pioneer of this, and when the war broke out insisted that these facilities should be provided for service people who got injured in the EMS [Emergency Medical Service] hospitals. And those EMS hospitals as you know were, were open to servicemen, to war casualties and others that had direct, [were] directly injured as a result of the war. And so, there was a facility for this, but it was I think, I think it's true to say it was the Air Force who really took the thing in hand because of the enormous shortage of pilots. And they were discovering that a pilot who had a simple Colles' fracture might be six months off, with a stiff wrist and unable to move the controls, and a person with a fractured tib and fib – tibia and fibula – might be off for a year. And even a simple meniscectomy – it might be months before they, they got back because there was no organised post-operative intensive rehabilitation programme. And so it was the initiative of Reginald Watson-Jones and Henry Osmond-Clarke, together with Jamie O'Malley(?), who started this. And the first centre was developed at Babbacombe, just outside Torquay – it was a, was a hotel, and...

MAM This was ... in?

CWP In 1940.

MAM '40.

CWP And the idea was that the patients would be sent there, and they would have exercise and fresh air and walk about, swimming in the, in the hotel swimming pool. And, but unfortunately a bomb hit the hospital in 1941, and a number of patients were killed, and so the ... unit was moved out to Loughborough. And in fact there was where the real regime started of an intensive exercise programme with classes with early non-weight bearing classes progressing, if you had a fractured leg for example, to early weight-bearing, and then on, and then finally full weight-bearing and intensive activity and to fit you for full duty. And it proved an enormous success. People were getting back to duty who would be previously off for months, back in three or four weeks. And, and of course this was tremendously cost-effective as well as very humanitarian, and it was followed up by the opening of a number of other centres throughout the country. In fact, there were seven during the war at any one time. And in the war, twenty-five thousand patients went through these centres, of which seventy per cent got back to full fighting duty, twenty-five per cent to some form of modified duty, and only five per cent were invalided. And when you consider those involved had very severe burns and multiple fractures and head injuries, that's a, a very remarkable result.

MAM These were mainly war trauma…

CWP Yes, yes.

MAM …rather than operations as such?

CWP Oh yes, yes. Although of course, you know, that would feature in it for somebody who got injured on the football field, and he would, he would go afterwards.

MAM Yes, yes.

CWP But it mostly was trauma.

MAM Was that multi-service or...

CWP No, this was exclusively RAF. The Army developed a number of centres which were called in the early days conditioning centres, because they were so appalled when the war broke out at the very low standard of physical fitness of the recruits who were underweight, and very poor physique, and unfit, and wouldn't pass the … you know, the entrance, the physical tests. And so they developed a number of these physical conditioning centres, which then became a similar sort of rehabilitation service.

MAM Were they doing a double bill, in fact…

CWP They were, yes.

MAM …to sort of build up the recruits but also rehabilitate or … actually the injured?

CWP That's right. But of course eventually in the 1950s, the RAF and the Army combined their services. And the, the big unit where I worked most of my life at Chessington was a joint services medical rehabilitation unit. And the Navy indeed had also a similar set-up down at Haslar, a very good one. But they let that sort of drift after the war and tended to use us if they, if they needed intensive rehabilitation.

MAM Oh I see, so it became an, an all-service facility later on?

CWP Yes, although most naval, although most naval patients, if they weren't fit to climb up the ladders of their destroyers and battleships then they were invalided, so there wasn't the… Whereas in the Air Force it was terribly important to get our very skilled men back into, into duty, because it was very expensive to invalid a man, pay him a pension and then train somebody else. And it wasn't only pilots. It was estimated that if you rehabilitated two pilots in a year, that paid for the whole thing, because it cost half a million pounds, the … when I was in, to train a pilot. It's very much more now. But even the air frame fitters and the engine fitters were very skilled men of many years training and experience. And so it made sense, if necessary, to have them at Chessington or Headley Court for months, if they could get fit at the end.

MAM And you could get them back again?

CWP Yes.

MAM That record of, you know, sort of seventy per cent is a remarkable one isn't it, and presumably far in excess of anything going on in civilian, even spas, let alone hospitals before the war?

CWP Yes, yes, that's right.

MAM Did they…? Just going back in time, was there any development in the First World War for taking soldiers, either to make them fitter but also to rehabilitate the injured?

CWP No, I think, as far as I can make out, it was really [that] they were sent to the spas, if they had a special problem.

MAM I see, right.

CWP And there were a few of these hospitals that had what we would now call rehabilitation facilities, but it wasn't organised and the treatments tended to be very passive. And right in the early days when I was training, there was an awful lot of passive treatment and physiotherapists were expected to give electrical treatments by the clock, prescribed for twenty minutes, and then maybe there's be some exercise…

MAM This is to strengthen muscles?

CWP No, no, this would be to relieve pain. A great deal of the physiotherapy in the early days was so-called palliative. It was relief of pain, relief of muscle spasm, and then improvement with exercises but there was… And the poor physiotherapists were then required to do very uninteresting and not very exciting treatments. In fact, many of them regarded themselves as electricians, just turning on and off electrical machines to order. But, and it's a great credit to many of the pioneers in the physiotherapy profession that they saw that this was inadequate and, and insisted on developing techniques like proprioception neurofacilitation techniques, which physiotherapists invented in the, in the early fifties, and showing what an awful lot you could do by exercise techniques and by a comprehensive integrated programme, to get people better.

MAM Now tell me, in, you … went into the Air Force in '48?

CWP Yes.

MAM That was after the Health Service came in, and at the end of what I would call the service heyday of rehabilitation from 1940 to say '46. Could you just describe the, the sort of regimen that they introduced in 1940 to get these chaps back? I mean, I can see the need, I'm sure the Air Ministry said that we need pilots… But … how, I mean there was very little experience around, well what, what regimen did they introduce?

CWP Well I think it was again Reginald Watson-Jones who realised that the people in hospital after an operation would just lie about. And he said 'Now this won't do. Everybody's got to exercise, and if nobody else is going to do this then we'll get the most enthusiastic patient, and we'll train him, and make him...' And they were taught, quadriceps exercises or whatever it was after knee operations, and they made the whole ward do these exercises every hour on the hour. But of course it was the most enthusiastic people who got better quicker and left, and so he said 'Well we need, we need an organisation. We must have some hospital rehabilitation men', who became the PTIs [physical training instructors] and later the remedial gymnasts, who have their own profession [and] are now, of course, amalgamated with the physiotherapists.

MAM PTIs are physical trainers?

CWP Trainers, yes, but for thirty years or so there was this profession of remedial gymnasts in the services, wonderful men, who ran these classes. The idea was that you were admitted in the early stages after, say, a fracture and your leg in plaster, and instead of hobbling around ... having the odd outpatient treatment and staying at home, you went to a residential centre. You joined a class where because you were non-weight bearing you sat down, or in the gym. But you exercised – you raised you leg up, and with, with increasing weights, and you played games so that you sat down playing volleyball and you would throw the ball, and every time you lent forward you were exercising your muscles. And you would do this two or three times a day. Then you would have walking and training in front of mirrors. Then you'd go for a walk. And later when the plaster came off you would go on cycle rides, and you'd go swimming, have hydrotherapy, and then occupational therapy if you had an arm or a hand problem. And of course in the Air Force we had special workshops in our rehabilitation centres with air frame fitters and engine fitters and radio operators posted in to instruct the patients in these things. So that they would both be using their hands as part of the treatment to get back movement in stiff joints and power in weak muscles, but also revising their own skills. So that when they left the, the unit they would not only be fit, but they'd be back to their own skills or very near there so that they would be fit for duty <u>on</u> discharge, and not fit for six weeks sick leave to get back or whatever it was. So it was all very much a dynamic, progressive, integrated programme, and then of course the physiotherapists joined and did the very skilled treatments. And many of the advances in physiotherapy I am proud to say came from the service physiotherapists and particularly the civilians who were posted in there to do... People like Maureen Salter and Lesley Baker(?), and Vicky Frampton – not Vicky Frampton, she was later, but – and Nathalie Barr as the occupational therapists who have all subsequently written books and made pioneering...

MAM They were in the, that development in the services?

CWP That's right, that's right. And of course the PTIs were magnificent because they had the brunt of the work because they had the men in their classes, you know, for hours on end, and not only had to instil in them the importance of work and exercise, but also to keep them amused. And so there were all sorts of games and *badinage* that went on, and the atmosphere was terrific. I mean, the camaraderie was wonderful and the, and there were some very distinguished people in the early days. I

remember that Flight Lieutenant Dan Maskill(?) was one of the first PFOs – physical fitness officers – and there was a certain Sergeant Leonard Hutton, who worked in... And there were many of these very famous sports people, you know, who came in and did all this work, and we owe a lot to them.

MAM Presumably these, these were already heroes in their own right, and therefore very attractive to...

CWP That's right, that's right. Oh yes.

MAM You must have come across in the services those who actually did not want to get better. Could you spot them and do things, or... Certainly not you, but...

CWP Yes, I think it became... Because, you see, there were so many people seeing them throughout the day... There was the class instructor who was chosen for his understanding of men, his man-management skills, his ability to inspire people to get, want to get well. And there was the physiotherapist who had them and had one-to-one experience with them, the same as the occupational therapist. And we had of course our team meetings once a week, which were very ... very relaxed and informal – everybody could say what they thought. And somebody would spot this. Some of them might be timid and frightened. Some of them thought well this is a cushy job, here we are, you know, it's jolly nice at Chessington or Headley Court, we don't particularly want to go back to our unit where, where we might have to work rather harder. Although they were made to work hard there, some of them felt this was...

MAM Rather different.

CWP Yes. But ... the spirit of the place was such that most people were caught up in it and were shamed into, into this. But we, yes, we usually could spot... Somebody would spot something and then we would, we would take him. I'll tell you, perhaps in passing, an anecdote which might indicate... There was, there was a patient whose service had better be nameless but it wasn't RAF, who had a recurrent knee effusion, and we could not seem to get this better. We'd see him one week and the new fusion would be done, we'd say go one more week and work hard at your quadriceps, and then the next time would come and he'd lie up on the couch and say 'I'm terribly sorry, Sir. It's all come up again.' And I thought I don't know what, what we are going to do with this. But I had a patient who I did one or two good turns. I'd heard he was a, he was an apprentice jockey, and I gave him some sick leave at a time when it was quite important for him to ride in a certain race. And he felt he owed me a certain reward for this, and when he was leaving he said 'Sir, I know you are very worried about these, some of these people with their knee effusions.' I said 'Oh yes, it's, it's terribly concerning, we just don't know why.' He said 'Well, I'll tell you, Sir, those of them who don't want to go back to their unit hit their knee the night before, with a spoon, to get the effusion up so that in your clinic it will all be swollen.' And so this chap who kept coming week after week with this effusion, I saw this thing, and with my newly acquired knowledge of this I stood over his knee for some time and shook my head and said it was very worrying. And in a quiet voice I said 'Do you use a wooden spoon or a metal spoon?' And he said 'Oh, a metal sp... Oops!' And that was the end of that!

MAM You cured him?

CWP Yes, we didn't have any more problems with the effusions from then on – the word got round!

MAM Lovely! You described a, a scene of, one, an urgent need to get highly skilled people who were injured back into service because they were a very precious commodity…

CWP Yes that's right.

MAM …a scheme which was obviously thought out and driven by a few outstanding doctors, but a scheme which was in fact run by non-doctors from your physical fitness people, even patient leaders and physiotherapists, to secure that. That would be a fair interpretation?

CWP Yes, it was a team.

MAM A real team effort.

CWP Yes. It was an absolutely integrated team. That was what was so exciting about working there, because we were all in it together and we were all learning. I mean, we knew nothing about how to treat hand injuries because there was nothing in the books, and suddenly we found at Chessington there were twenty or thirty people with crushed hands and tendons all stuck and, and what do we do? And so we just had to settle down and say 'Well now, perhaps an intensive programme of massage and serial plasters such as you would use for stiff knees, and exercise programmes and games and occupational therapy…' And we used to devise various games for particular problems with the arm, so that we would have race games devised so that they would only operate if you twisted your arm very fast, to get back rotation after fractures of the radius and ulna, and so on. And we had a wonderful beat-the-clock game that you had to get a lever through a whole series of gates. And each gate was opened by a different hand movement, or a different thumb or finger movement, or something, and it was timed so you raced against, other patients raced against each other. And I understand money occasionally changed hands, but of course we didn't want to know about that. And this was, you know, incentive is all. And this sort of thing, you know, we realised we were getting good results, but it was the integrated effort of these people who all gave their ideas and, you know, and worked as a team. And a very happy team it was.

MAM Now, I suppose these days we have a lot of jargon about evidence-based medicine, you must do randomly controlled trials. Here you were in a wartime situation, desperate to get these people back and cured quicker. You don't have time for randomised controlled trials and was this better, you were playing it 'on the hoof', if I can say that. Presumably you kept records, presumably you were either overtly or subconsciously aware that some things were better than others. Did you keep meticulous records of how people were doing, or…?

CWP Yes. You see, in the, in the early fifties, well actually throughout my career in the services, there were always worries about whether they would go on funding this.

As the services began to be cut and money began to be shorter and people had to do more jobs, there was always the fear that one of the things that would go would be the rehabilitation centre. You know, is this a luxury, you see, and particularly Headley Court which opened in the fifties, which is a very beautiful building. I don't know whether you have seen it. It's down ... in Surrey.

MAM I've seen pictures of it.

CWP Yes, and it was Baron Cunliffe's residence and the auctioneers and estate agents gave it to the Air Force in memory of the Battle of Britain as a rehabilitation centre and, of course, it's wonderful. It's got panelling from Cromwell's time and I believe Cromwell's ghost is seen from time to time, and wonderful grounds. And of course it's very easy for people to say 'Well now, is this, you know, do we really need all this?', you see.

MAM It's a big luxury.

CWP And, so it occurred to me when I was put at quite an early stage in my career, because there was nobody else to, to be in charge of rehabilitation, that it would be best if we tried to prove the case. So, we did keep very careful records, and we published a series of papers, for example showing... We had I think a hundred and fifty patients with fractured femurs, and we showed the length of time it would take if you have a nail in, if you had, treat it with traction or with plating, and how long it would be before you got back to full duty. And we followed these people up and saw what happened to them, and we published five hundred and fifty-five cases of fractured tibia and fibula that I got from all the units and showed how long it would take. And the same with meniscectomies. I know we wrote a paper on the results of one thousand seven hundred and twenty-three patients after a meniscectomy, which was quite a lot, actually the biggest series ever published at the time. And we did some control trials on various ways of treating knee effusions and various ways of producing, getting back muscle power after injury. And I used to tell all our, our staff that we must do this to prove ourselves because, you know, we've got a wonderful set-up here, we believe in it.

MAM That, and I'd like to come back to that because that was something you were directly involved in, but in the war, at the start of the war, '40/'41... Presumably they, I mean they kept notes, but it was, it was to a certain extent just practical experience of things that worked and didn't work?

CWP Well, yes. Well, it was great men like Watson-Jones saying to the Air Ministry 'Well, look, you know, these people are getting back in seven weeks which took a year before.' And that was the end of it. And he could see that pilots were, you know, coming back and...

MAM But this was, to a certain extent, rather a faith and trial and error rather than any great randomised trial or anything...

CWP That's right.

MAM It was, it was just a belief that you did this?

CWP Yes.

MAM Now one other question that intrigues me is that the wartime situation, and indeed my experience of the Air Force at, say, Chessington, which we referred some airmen to... You did have the advantage over and above the Health Service of being able to admit service personnel, i.e. they were transferred, you know, off duty in station, and you had them all the time. Now, I can see problems in having them all the time because you, to a certain extent you can't do exercises all day and all night, so you, and ... you must have some entertainment to keep them busy. But you do have an advantage of having the chaps where you can literally have 10 o'clock, 11 o'clock, midday, a rest and all through the afternoon. Now, presumably the Health Service had very few facilities to take people in on that basis. I was at King's, and agree with your assessment of Cooksey, but I think he only had two beds or something. So all his patients, some of which came I must say for the day... But there didn't seem to be quite the same intensity or the same team spirit if you like, as you had in those days in the forties to '46. Would that be true?

CWP And still have, because even now today, if a patient requires rehabilitation he is posted to Headley Court and his job is to get better. And he is on full pay and allowances, so there's no worry about the family, or mortgages – he's there to get better. And you go on until you get better. And the great old days, I remember, when we had... You see, it all started as an orthopaedic service, and then we gradually developed it and took in patients with rheumatological, rheumatological disorders. And then the neurological disorders, particularly head injuries, because these were an increasing number of people – as you know when crash helmets came in people were surviving these injuries. And we had many, many people with severe head injuries. And it became clear that it wasn't the physical aspect that was so difficult. If somebody had a weakness or hemiplegia, well, that was something you could, you could cope with. One knew that it was the cognitive deficits – the memory disturbance, the behavioural disorders – that really presented the challenge. And here it was clear that you needed a really long-term set-up. You needed a ward where these people could be nursed properly and special rehabilitation nursing, and you needed psychologists. And so Chessington employed up to, at one point three full-time clinical psychologists and an education officer especially...

MAM These were predominantly head and spinal injuries?

CWP Yes, yes, head injuries particularly, and a special education officer was brought in to assess their cognitive abilities and help to re-train them. And this was ... Chris Evans, you know, who subsequently went to Rivermead and then to Truro, wrote an excellent book on rehabilitation for head injuries,[4] and showed that fifty-one per cent of all the severe head injuries, severe being, you know, unconscious for more than a certain time – 48 hours, fifty-one per cent got back to duty, even though it may take months or even sometimes eighteen months. But they got back, and this showed that with this sort of integrated programme it could be done. And I think that that became clear in the Health Service – that these sorts of results could be obtained if you had an integrated programme, and it could well be done as an outpatient and it

[4] *Rehabilitation after severe head injury*, ed. by CD Evans, Edinburgh: Churchill Livingstone, 1981.

had to be, of course. We had a few residential centres after the war – Garston Manor, Clacton, and one up in Durham, and Farnham Park which became very good for sports injuries. But eventually it was clear that as the doctors got more interested in this, they didn't want to send their patients away to be rehabilitated, they wanted to look after them themselves. And that's absolutely understandable because I went to Stanmore, I was able to organise a similar sort of Chessington set-up with a mini care ward where people were rehabilitated, but as I used to say to my surgical colleagues 'You want, you want to see your patients through. And this is what we, what you should be able to do. It's better for everybody, you know, if you can see the patient.' So the idea of residential rehabilitation away from the hospital gradually died out. It happened in the war (?) ... because you've got to be away from, you know, you couldn't have a rehabilitation set-up in every hospital.

MAM You had to have centres?

CWP Yes, and they had to be right away in the country, you know, away from the bombs.

MAM Presumably there was less worry from ... these chaps being removed from their family in that a lot of them weren't married anyway because they were young...

CWP Yes, that's right.

MAM ...whereas the NHS presumably was coping with head injuries of people who were married, so there was a limit to being able to send them away for eight months or something?

CWP Yes, yes. Well, there's no doubt that of course the more intense the treatment you can give, the better and quicker the results. I mean that we showed, and I mean there's no doubt there is documentary evidence <u>now</u> that this is so.

MAM But, not really feasible for most of the NHS cases. I suppose would there be a compromise of netting, say, for a fortnight and then going on?

CWP Yes. You see, Donal Brooks, whom I had the great privilege of working with at the Royal National Orthopaedic Hospital, the great hand surgeon, he made patients sign a certificate saying that if he took them on and did the attendant graft or attendant transfer for a peripheral nerve injury, they would come back three weeks after the operation for two weeks intensive inpatient rehabilitation. Unless they signed that, he would not do the operation. He said 'Rehabilitation is part of the process and unless you are prepared to come in, I won't do it.' And of course the results were marvellous, because they had six hours intensive treatment. It had to be in the ward but, because we didn't in those days have a mini care, but when I, when I went there then I provided that service for him so they could be transferred to the mini care wards much cheaper. And much better for the patient because he was, you know, up and about and active and not in a hospital bed, and it worked.

MAM Now, we've come through the war, we've got an NHS, we've still got the services with a number of facilities, presumably opening up to civilians at this stage some of them, or some of them would be offering help to civilians, and one or two of

NHS establishments now for the ordinary non-service public. You ... sitting in pharmacology at Oxford, decided no, I've got better things to do, and elected quite deliberately to go into the Air Force as being the leaders in this field which you wanted to embrace. 1948 I think you said was the time you entered the Air Force to do this. What was the state, if you like, of rehabilitation at that stage? We've had the war, we'd ... to a certain extent developed after the war, we now have the, the start of the civilian service, proven that rehabilitation worked. What did you find on entering in 1948, albeit(?) a service, where did you go, and...?

CWP I, well I went first to Cranwell for three months, sort of, you know, to learn what a junior(?) medical officer was like, which I absolutely loved, and learn what flying was about and the mystique of the flying men, and went up in aeroplanes and experienced this.

MAM Terrifying.

CWP Yes, absolutely terrifying. You know, barrel rolls in Meteors – absolutely awful. Anyway, I loved that, and I realised that there was something very special about the camaraderie as you and I know, because you were in the Air Force and a very distinguished career you had, although it was short. We, we know that it's the man in the sky that we're all working for, so one has a, one has a ... a mystique there, you know what you are about. And when I got to Chessington... I went to the CME, to the Central Medical Establishment, first and ran clinics there. And that's where I learnt to do electromyography with Bowes[5] at [St] Thomas' and provided a service there. And then it was decided I should go to Chessington and really start. So, I went there in 1950 – '49 I think, '50 – and there I found one other doctor who was a squadron leader, Squadron Leader Robb, splendid Scotsman, and he and I and a unit medical officer had to look after over three hundred patients. It was an enormous clientele.

MAM These were all patients for...

CWP All servicemen...

MAM ...for rehabilitation?

CWP ...because there was conscription as you know until quite late on, and these were getting sports injuries and road traffic accidents, some war injuries because [of] Aden and Malaysia, there were terrorist ... activities. And there was this huge amount of patients that... And that's where as I said to you earlier we realised we'd got this wonderful captive audience, and I said 'Well, we'll, we'll make some measurements, and find out, you know, and see what happens to them, and get some facts and figures.'

MAM Presumably you were carrying on what the predecessors had chosen to do, the principles?

CWP Yes, yes, the class structure was there but it was all orthopaedic. I think it was

[5] Robert Kenneth Bowes.

I and my colleagues – Chris Evans and one or two others – who … diversified into the rheumatological side because at that stage we of course were very closely involved with the Health Service. I, I used to be, have contact with the Royal National Orthopaedic because I'd been at Oxford and knew Donal Brooks and Herbert Seddon. So I sent the brachial plexus patients there, and used to go regularly to their clinics and learn what they were doing.

MAM Brachial plexus being…

CWP The, the traction…

MAM …the tearing of these nerves...

CW The, tearing of these nerves, yes, which I subsequently got very interested in and did some work on. And we also of course had to go and do this, the Diploma in Physical Medicine, which was devised in 1944 as the qualifying diploma if you were going to practise what was then called Physical Medicine, which was a mixture of rheumatic diseases and, and looking after physiotherapy departments and providing rehabilitation facilities, and some people doing electromyography. It was a marvellous mishmash, but it was a very good training because you had to… The Diploma in Physical Medicine, the Part One I remember was anatomy, physiology and physics. We had to understand how these machines worked, although of course if anything went wrong you, you looked inside and you sent for the manufacturer, you know, and he got frightfully cross if you did! But you were supposed to know how they worked, perfectly reasonable, because if you were asking physiotherapists to do something, you should know what, what you were asking them to do. And the second part was a very good clinical exam in general medicine, neurology and rheumatology. It was a good exam, and one, you know, you had to work hard for it and get a lot of experience. And to do that one had to get experience in London hospitals. I went to The London under Will Tegner and subsequently Michael Mason, and learnt rheumatology there and set up an EMG [electromyography] service there. And other medical officers used to go to other, to the Hammersmith Hospital and other… And so there was a constant link, and the physicians, the clinicians … the civilians were very intrigued in this and they used to come and visit our centres. And of course, as you know in those days the … surgeons didn't have always the services they'd want for rehabilitation. And it was Herbert Seddon who was a wonderful man and tremendously supportive of fringe people like myself – if he saw something was needed he backed them. And he backed me and was extraordinarily helpful, and he asked me to go and lecture at...

MAM He was … a surgeon?

CWP A surgeon. He was the, he was the professor of orthopaedics at Oxford, and then he moved to London and became the professor of, of orthopaedics at The Royal National Orthopaedic Hospital at Stanmore, and wrote the definitive textbook on surgical disorders of the peripheral nerve,[6] and was world famous, and invented tendon transplants. And during the war at the MRC set-up in Wheatley, he designed the whole system of categorising and classifying nerve injuries into neurapraxia,

[6] Sir Herbert Seddon, *Surgical disorders of the peripheral nerves*, Edinburgh; New York: Churchill Livingstone, 2nd edition, 1975.

axonotmesis. All that's his work. And wonderful records kept about what happened to all these people with peripheral nerve injuries, how many got – what sort of recovery after median nerve lesions, and careful records were kept. And this was really good science and good clinical medicine. He was a marvellous man. And he asked me if I would like to come up and talk on rehabilitation at a meeting of the Hand Society[7] – there was a newly formed Hand Society in Glasgow – and, and I did. I spoke on rehabilitation, and Seddon was kind enough to say that 'That was an important talk. I want all you surgeons to realise that your job isn't done when you put the knife down. You must see this through and these facilities that the services provide are what you should have.' And so lots of ... my colleagues there, hand surgeons, I got to know very well because I was asked if I'd join the club, sent their patients to us because they knew we could give them six hours a day intensive treatment. And so, the Air Ministry in their wisdom accepted that. They said 'That's very good.' And they won't charge, because, they said 'It's very good for us to be seen as co-operating and helping out. And also it's frightfully good for you chaps,' like me, 'to get the experience so that if the balloon goes up again we'll know what to do.' So, at any one time I might have thirty severe hand injuries of which five or ten were civilians, and this went on for years and years. So we got marvellous experience and, and of course it meant that there was closer and closer collaboration between many of us in the civilian field, so...

MAM Yes, you saved yourself from that service isolation or the potential...

CWP Yes, that's right, that's right. Yes, exactly.

MAM And this was Chessington?

CWP Yes.

MAM Yes. What about head injuries, which must have increased actually – the severe head injuries?

CWP Yes. Well, that's when we developed the special head injury unit at Chessington.

MAM So, you had an, an actual unit?

CWP Oh yes. It was part of the set-up but we had a special ward for these patients where they would live, because many of them were very severely disabled and had lost their memory and couldn't get round the unit. Part of the job was to teach them how to find their way with various ... methods of, you know, of re-education of memory and spatio-temporal deficits. That's when we introduced the psychologists and the special education officers, and occupational therapy designed to help with the early stages, and when Chris Evans wrote his, his book on this.

MAM Now, while you were at Chessington, did you become medical director for the RAF at that stage, or...?

[7] British Society for Surgery of the Hand.

CWP I became the, the director of rehabilitation, but it was called consultant in physical medicine and then later...

MAM Oh, I see, yes. The boss man...

CWP The boss man, that's right.

MAM ...on, on the medical side.

CWP Yes.

MAM Did you, I imagine you must have, develop particular interests and skills for your own work apart from the overall running of, of rehabilitation? Could you tell us a little bit about those personal interests?

CWP Well, I think the, one really reacted to what one saw there, and the sort of orthopaedic side was, was fairly well set out already. I mean, we knew what to do with fractures and dislocations and meniscectomies and so on. There was a good ... system laid down, although there were new advances all the time in orthopaedic skills. But basically it was getting people to walk again, to get the muscles better and their joints going and to be, get their confidence back. What struck us were these large number of complex hand injuries and the brachial plexus lesion – the people who have torn the, all the nerves out of their spine, and not only have they got a paralysed arm but they suffer this appalling pain which is a feature of deafferentation...

MAM I was going to ask about that? Is that, is that while the nerves are healing, or...?

CWP Oh no, no. When you, when the nerves are torn right out, a preganglionic occlusion, which as you know there is no possibility of, of recovery...

MAM Oh, I see.

CWP ...the nerve cells at that level in the spinal cord, and lamina is one, start firing off spontaneously because normally they, they react to a stimuli, no stimuli are coming in. And their reaction is to fire off as if it were saying what's going on, why aren't I being told anything, you see.

MAM So, you are losing the sensory input?

CWP Yes, but there is a massive electrical discharges going on in the nervous system which is felt as pain.

MAM Oh, I see.

CWP And this is a severe – it's like the...

MAM Is this the phantom...

CWP ...if you lose a leg, it's a phantom limb, people can get phantom pain. About

ten per cent of people who lose a leg get very severe pain even though the leg's not there. There's no input coming in, but the cells are firing away, saying what's going on, you know. And these people get terrible pain and, of course, they have a very severe disability, many of them are totally paralysed.

MAM Do you lose all function?

CWP Everything – all function, all sensation, all that.

MAM With very little recovery?

CWP The earlier... Oh, if you had them torn right out, no recovery. At the moment we can't repair this although there is exciting work going on in laboratories and I am sure this will come. You will be able to replant nerves if you get them early enough, but not at the moment. And all this period I am speaking there was the, the classical treatment of people with a severe brachial plexus lesion in the fifties was amputation, arthrodesis and putting on an artificial limb. But it became clear, and Ransford and Hughes wrote a very good article in the early sixties saying the vast majority of people in which this is done don't use their arm.[8] They leave it on the top of a shelf, they bring it in for outpatient review, but they don't wear it – it's clumsy and it's difficult. And if you've got a total paralysis you haven't got the muscles that project the scapula forward, the serratus is gone, so putting an artificial arm on is honestly no good because you can't actually use it properly.

MAM You can't really use it.

CWP And, so that was abandoned. And then, we devised a modification of the splints that Roehampton originally devised, the flail arm splint, and we made a lot of ... modifications to this over the years, and had some very ingenious people from Steepers...

MAM Flail arm meaning paralysed?

CWP Flail arm, it was... Yes. It was a splint like an artificial arm over the patient's own arm. So you had a shoulder support, you had a ratchet here with a locking device so you could put the elbow in one of five positions, and a trough in front of the forearm into which you could slot the normal artificial arm appliances – the split hook and the universal tool. And the patient could either then fix his arm in this position, and hold something whilst he used the other arm – if you told him to saw he'd saw with one arm, hold the wood with that, or he could have a cable put on, so by shrugging the normal shoulder he would open and shut this, like you do in an artificial limb. So it had the advantage that the patient kept his own arm. And many of these young men don't want their arm off – they don't like to be seen in a swimming pool with a stump. But most people don't notice you've got a flail arm, it's very unobservant, but they actually notice if you've got a stump there, so you were glad not to have it off. And it meant that they could get the splint put on. And these splints were modular – they were small, medium and large – they could be fitted and the patient trained to use it within ten days. And then they could be back to work, having

[8] AO Ransford, SP Hughes, 'Complete brachial plexus lesions: a ten-year follow-up of twenty cases', *Journal of Bone and Joint Surgery (Britain)*, 1977, 59-B:4, 417-20.

learnt how to use it for whatever job they wanted to do. So this really revolutionised the management of these people because they were able to get back to the community quickly, with some sort of device. And employers were much more ready to take somebody if you said 'Well, he's got a bit of a problem with the arm but we've got a device to help him', than if you said 'Well, he hasn't got an arm at all.' 'Oh, he's dangerous, can't have him on machinery,' you see. And one of our great, our great achievements in the early days was a really lovely young man called Hartley(?), whom we all became very fond of who had got a motorcycle accident and had one of these complete paralyses. And we provided him with one of these splints, and we showed in our OT [occupational therapy] department that he could do his job – which was a man working with engines, an engine-fitter, a rather specialised sort. And I rang up his, his MO and said 'Well now, Hartley is a very good chap, we like him, he's got wonderful spirit and he's a very amusing fellow. He's now ready to come back to work.' He said 'Oh, is he recovered?' I said 'No, he's still paralysed, but he's got a splint and can do his job.' 'Oh, we can't possibly...' you know. And I said 'Well, why not? He's, he can do his job. Isn't that what he's for?' And I said 'He, it's his right arm, and he's been given permission here not to salute, he just looks very smartly to the right,' – that's really all he wants that arm for, you see, is to salute – 'the rest of it, he can do his job. Why can't you take him back?' So, there was a lot of humming and hawing. 'Oh, this is really a bit of a precedent.' And I said 'Well, that's what the Air Force is about, isn't it? Now, come on.' And he said 'Well I'll give him a DC[9]'. And the SMO [Senior Medical Officer] there was a very good chap and he said 'Okay, I'll tell you what. We'll send him on this course, and if he fails the course, that's it, invalided, but if he gets through the course, then we'll, we'll think about it.' So he went on the course for six months, passed top, and subsequently from being a...

MAM Which was mainly ... physical rather than mental?

CWP That's right, that's right. And he came top, and he ended up as being a flight sergeant with a full career and still wearing his splint. I saw him many years later. He came back to Chessington as a patient and I said 'What's happened?' He said 'Oh, I've, I've broken my leg.' I said 'How did you do that?' 'On my motorbike!' So I mean, you know, that's the sort of chap you want, you know. And so we were able to instil in people that we would, you know, it's what a chap could do, not what theoretically he ought to be like. And then of course, as you know, seatbelts came in, and helmets. And so a vast number of, of people who would normally have been killed on motorcycles were there for rehabilitation. And we used to have about ten or twelve at any one time and I've, I've actually written up four hundred and forty cases of severe brachial plexus lesion and what happened to them. So we learnt how to treat their pain or help with their pain.

MAM Now what about the treatment of pain, because I can see you obviously did wonders in keeping the arm and flail arm splinting, but what about this pain which you said...?

CWP Well, we actually followed up these four hundred odd patients to see what the natural history of the pain was. And we found that most people – I think it was nearly

[9] DC – standard test to measure numerical ability, verbal and non-verbal reasoning, and language comprehension.

ninety per cent – either lost the pain or it became, became acceptable, so they got used to it and could cope with it, within three years. Now, there are a lot of people who now, surgeons who say 'Oh, you can do these special operations for ablating the entry zone of the dorsal root where all this nerve activity is going on, and therefore you should do it quickly.' Well, that's a bad idea because [for] many of them the pain comes back, and after all, if the natural history is within three years for most to get better, it's better to stay the hand. So that's why we thought we'd better find this out. And during that time the one thing we learnt that really helped these patients was distraction, that if you could get them really interested, they'd bring in their central inhibitory pathways, which we know exist on a short-term basis, and train them. As you know, the story of the Duke of Uxbridge and the Duke of Wellington at Waterloo... You know, the Duke [of Wellington] turned round to the Duke of Uxbridge when they were looking at the battlefield from on high and said 'My God Sir, your leg's been shot off!' And Uxbridge looked down and said 'My God, you're right, I hadn't noticed!' Because he was so absorbed in the battle. But of course, we all have...

MAM That's a bit extreme!

CWP Well it is extreme, yes, but you do in fact have a system that will gate off pain in an emergency, you know, if you get a sprained ankle and you're hobbling down and you see a snake, you run like hell. You can. You can switch this on. So part of the thing is to mobilise this and help people to come to terms with it. And of course work, meaningful work, is the best way of distraction. And if you give a chap a splint and say 'Right, now you can get back and learn a trade or do it,' then the chances are he may be able to get this pain under some sort of control. But other things are...

MAM Are painkillers any good, or...?

CWP No, very few. The narcotics don't work with deafferentation pain, which is an extraordinary thing. Some of the more powerful ones can sort of damp it down a bit. The thing we found most helpful was the transcutaneous electrical stimulation [TENS]. And at Stanmore where I carried on this work and developed it much more, as we were a referral centre for brachial plexus for the whole country because of Seddon and Brooks and Philip Yeoman's work... So I was given the job of rehabilitating these people. And subsequently Rolfe Birch, this brilliant surgeon who is now at, at Stanmore, who'll now operate on these people and can repair these ... torn C.5/C.6 roots, which are torn not out of the thing but are ruptured distal to the ganglion, and can be repaired. But the lower roots are often torn right out. So you get this complicated picture of ruptures of the upper roots, which can be repaired so you can give back some elbow flexion and sometimes a bit of hand, but the lower ones are torn out which produce this paralysed hand and terrible pain. So you've got to repair them, splint them, and get rid of their pain. And we found that the electrical stimulator was the most useful way, but used very intensively, several hours a day, day after day in different positions and different frequencies. It's all got to be done very carefully. And the physio is there. Particularly Vicky Frampton, who was marvellous at this and did some very careful studies, keeping pain diaries and seeing what effect this had. And we showed that sixty per cent of these people with severe pain got substantial relief, if given properly. But that, and intensive work, was the ... getting back to some meaningful activity, or hobby. We had an extraordinary man

who works on the airport at Glasgow who had a brachial plexus lesion. And he can keep his pain at bay by working in the airport – he has a splint and he does this. But the pain comes back once he stops and relaxes, so he does a night job…

MAM Oh, I see.

CWP …and that keeps him going there, and he only has a few hours sleep, but he said that's … that's it.

MAM I once had a theory that toothache is no worse at night than it is in day, but you have nothing else to do except think about it.

CWP That's right, that's right. I think that's right, yes.

MAM Now, that obviously was a main interest of yours, dealing with the flail arm, and, and pain. Did you have any other particular interests?

CWP What, in the service or, or...?

MAM No, I meant when you were at Chessington. Did you, did they have other interests?

CWP Yes, we were interested in the peripheral nerve injuries in general because there were a lot of those, and we devised some of these little splints which would give people function...

MAM Now they were caused by what?

CWP Median annular nerve lesions(?).

MAM Due to?

CWP Often putting your hand through a window, a fall, a crash injury, you know, all sorts of ways. But we again collected a lot of these injuries from our colleagues, because you had a great advantage from my being in the Hand Society that I met them all the time and they knew they could send them to Chessington. And we might have, you know, ten or fifteen people with peripheral nerve injuries, and over, over years this was hundreds. And of course these people would have a claw hand or be unable to bring the thumb across, and in all there would be a delay from definitive suture to the time they are going to get recovery, which might be four or five months, and they don't want to hang...

MAM This is for, for nerves...

CWP For nerve repair. And of course the hand was, was clawed up, on the nerve or the flat...

MAM So you would have stopped that?

CWP So, we'd make a little splint, a lively splint, which they would, they could

wear, and get back to work.

MAM In those days I think I would be right in saying there was very little nerve suture, was there not?

CWP They ... no, grafting came later. I think the... No, Seddon showed that the success of the repair depended on how much was lost and there was – above a certain loss you couldn't, you know, approximate anything without stretching it and would need a graft. But even in the war they were doing these amazing procedures.

MAM Oh, were they?

CWP But what they weren't, they were finding, I mean Seddon wrote in his book that after median nerve repair in an adult, you would only expect protective sensation and no true stereognosis. Now, of course, for the serviceman and the electronic engineer or the radio operator, this was absolutely vital, you must, must have this. The ordinary bricklayer, okay... And we wondered whether the same attitudes to principles of rehabilitation might be duly applied to the motor system – you know, progressive activity, use and all the rest of it – might work with sensation. So we started the idea of re-education of sensation, so when the patient got recovery of sensation, protective sensation – you know, you get pins and needles and burning, a rather unpleasant sensation – which Seddon would relate that would be return of protective sensation but not stereognosis. We then designed various ... regimes and re-education tasks to try and relate this funny feeling to function, that is, we would say to the patient 'Well when you feel that, does that feel like glass?' 'No, it feels a funny tingling thing.' So then we would blindfold them and ask them to feel it, different textures, different objects, and then we'd record what they said. Then they'd open their eyes, we'd take the blindfold off, and then they would see they'd made a mistake. And we'd say 'Now, that feeling which normally on your good hand is glass, now you've got to relate this new funny feeling to glass, and this feeling to china, and that feeling to texture.' And so we would re-educate them to learn a new coding for this abnormal sensation which, after all, is made up of, of...

MAM Is that permanent, that, is that permanent, that...?

CWP Well, we... Yes, we would find patients who years before had had repair and still had no proper stereognosis.

MAM I see, so...

CWP If they, if they hadn't learnt to use it, they never would. It didn't come back on its own, that's the point, or very marginally.

MAM Did this improve the return of full sensation? It actually...

CWP Yes. Oh yes, we got people back to, to [be] able to manipulate tools and things. And we even had a professional harpsichord player who was able to get back and play the harpsichord, not, not back to how she was, but she could teach and play...

MAM Marvellous.

CWP ...whereas before, you know, the sensation was so odd that she didn't want to.

MAM But, they were still in the position that, that glass in this hand, the injured one, didn't feel the same as...?

CWP No, no, but they'd learnt.

MAM They knew, they knew this new sensation was glass?

CWP That's right. There is, of course, a code in the nervous system for relating speed and, and amount of fibres that are in, after a nerve injury you lose fibres and the speed is slow, as you know, even now there is...

MAM I see. So, this is a re-...

CWP It's a re- ... it's a re-process.

MAM But you're still not actually improving ... to full sensation again?

CWP Oh no, but you are re-educating...

MAM Re-educating...

CWP ...on the grounds that the nervous system, there is an enormous amount of redundancy, and if you can bring out some of that... And it worked, so we, we felt that we'd done something there. Maureen Salter, our physio there, she and I wrote this up, and she did this marvellous work and we designed ways of testing it with objects and things. In the old days, people just used two-point discrimination[10], but that is a dead test. You, if you go to your tailor, you don't say to him 'Please lay a bit of cloth on my finger and I'll decide.' You have to move it. So, movement is part of sensation, and that I think we pointed out, that if you are going to test something you must allow them to do that.

MAM You've got to have the ... yes.

CWP Because you could use all sort of clues when you're feeling, there's nails and tendons and all the rest of it. And this, we, we feel we made a contribution there and I think this is now accepted as part of hand re-education now.

MAM Now, how long were you at Chessington?

CWP Boy and man – twenty-seven years.

MAM Were you really?

CWP Oh yes, I was... When I was fifty, and I felt well, you know, we possibly

[10] In this test two pointed objects are pressed on one area of skin, and a measurement is taken of the distance apart that the two points must be for the person to feel two points.

ought to have a career move... And I remember it was, [I] used to go up to the Royal National Orthopaedic at Great Portland Street and, and lecture there on rehabilitation of the hand because my colleagues there like Donal Brooks and Seddon and Yeoman were very kind to me, and said come and talk to our, you know, on our instructional courses. So I did. And Derrick Brewerton, who was this great ... rheumatologist at The Westminster as it then was, who did wonderful work on ankylosing spondylitis and more or less showed the H, HLA-B27 group was responsible, he was a great man. But he ran the physical medicine as it still then was at the RNOH, and when he was away I used to go and do the EMGs for him. But he was very much stuck at The Westminster doing rheumatology, general medicine and rehabilitation – he was an all-purpose man of great distinction, and didn't want to make a full-time job of Stanmore. And I remember saying to Mr Wilson[11], who was the senior surgeon, when after one of the lectures I had given ... saying, you know 'You ... very kind of you to ask me, but you really ought to have a full-time director of rehabilitation here, you know, like I am trying to do at Chessington.' And he said 'Yes, I think you're probably right, we ought.' He said 'If we make a job, will you take it?' I said 'Well actually, I hadn't that in mind, but now you really have made me think and worry,' you see. But in fact he was, Ginger Wilson was a super chap. And that's what's so good about orthopaedic surgeons – if they suddenly see that something makes sense, they get on with it, and there wasn't any sort of, you know, well do we want this...

MAM A job...

CWP It's right, there's a need here – we'll create a job. And I was successful in the application, and I was able to develop the same sort of principles, which is what they wanted. They said 'We want you to, you know, give us a professional rehabilitation service and provide a facility.' So I...

MAM And Stanmore was essentially an orthopaedic ... hospital, wasn't it?

CWP Yes, that's right.

MAM So presumably you introduced a, a rehab unit at Stanmore?

CWP Yes, I got a, I was, I started off by just doing clinics and going round everybody and seeing what they did and organising a co-ordinating service. And then I said 'Really, we want a mini care ward.' And there was a certain amount of discussion as you can imagine about this and finally I was allowed it. The matron as it then was, lovely – we had a matron, not a, you know, number one or whatever it is now – wonderful woman. And she said 'Look, this makes a great deal of sense.' And she persuaded everyone. And so I got a 16-bed mini care ward, and some of the surgeons who were a bit doubtful whether this would actually ever be filled realised after a bit that there's a way that they could move their patients on. And I said to them, you know, 'You go on looking after the patient, but if you want me to, I will, but it's up to you.' And they realised that I wasn't competing, I wasn't trying to build an empire. It really was providing a service and I loved working as a team in, you know, and I liked working with the orthopaedic surgeons because they like to do things and they are very positive, extrovert people, and, and that was fun. And so, we

[11] James Noel Wilson.

got this 16-bed ward going...

MAM So, you brought in your many Chessingtons into, to Stanmore?

CWP That's right, and within a year I had difficulty getting my own patients in because it was so popular. And then I said 'We want a, a female ward.' So we then at one time had 32 mini care beds, and it was a tremendous success, and I had about half of them by the end that I looked after.

MAM Were these mainly post-orthopaedic?

CWP Post-orthopaedic, but then we began to get people with head injuries. I presided over a head injury service. A lot of rheumatology because Lorden Trickie who was one of the senior surgeons who was, did a lot of the rheumatological surgery, he said 'Look', he said to me 'Can you, I believe you trained in rheumatology?' I said 'Yes.' He said 'Well, come on, give us a rheumatology service.' I said 'I'd love to, but I, but I didn't want to force it on you.' 'Oh yes,' he said 'we want, we want a medical rheumatology service. Right, you form it.' So, so I did, and then I had these wards, these beds, where I could, people, bring in people with acute joint problems and splint them and re-educate them and all the rest of it. And then of course we had joint clinics with the hand surgeons and George Bentley, the professor of surgery and joint surgery, for getting people in, getting them operated on and getting them back quickly. So it all, you know, gradually expanded.

MAM Being director of Stanmore presumably gave you an opportunity to educate your consultant colleagues and, and their juniors in, if you like, rehabilitation. So we could stop saying orthopaedic surgery – out, we could start looking at orthopaedic surgery – seeing your patient through with your help?

CWP Yes. When it got established that, that most of the registrars in training would come through the unit and spend one or two sessions, or more if they wanted, so that they all learnt what we were trying to do. So I tried to get the ethos across of what, and for them to respect the physiotherapist and the OTs [occupational therapists] and to go into their departments and learn what they did. And I used to get special instructional courses going so the physios would demonstrate their techniques, OTs to the nurses...

MAM These were all orthopaedic surgeons in training, then?

CWP Yes.

MAM Yes.

CWP Yes, there was only one other physician. That was Trevor Stamp, now Lord Stamp, the metabolic physician, with whom I had a lovely relationship because of course we had close links with osteoporosis and that sort of thing. It was enormously happy, and there was something going on all the time and I, I loved it, it was...

MAM Was Stanmore isolated in, in a sort of intellectual sense?

CWP Of course... Not in an intellectual sense because being a postgraduate institute and a tremendous amount of teaching going on, and postgraduates from all over the world coming for courses, and being appointed to individual firms to learn. And there was a very, very strong educational organisation there. For example there were, every Wednesday night there was a case conference and instructional course that went right through the systems in three years. You know, hand one term, hip another term.

MAM Oh, I see.

CWP And we were all encouraged to turn up to these, even though it may not be relevant. And I would very often go, simply to be seen, you know, the rehab chap is interested, and occasionally I'd...

MAM But you were a director as well?

CWP Director of rehabilitation, yes.

MAM Oh, I see.

CWP Well, only a director of rehabilitation, just a...

MAM No, I just wondered if you were a director of the hospital in a more general... No?

CWP Oh no, no, no. Oh no, only the rehabilitation services. But if I was seen there they'd see that I'm interested and I'd learn, and occasionally I'd be able to make a suggestion that, you know, if you sent us this chap we might be able to help and to, to try and become part of the team. Because so-called physical medicine rehabilitation – we were regarded for so long as second-class citizens, you know, we were ... there was, there was as you well know, there were problems ... in the early days. Physical medicine gradually split off between people who wanted to do more pure sort of rheumatological things, and those who wanted to provide a service for rehabilitation, which would mean in their departments looking after head injuries, MS, all sorts of things. And, many of the people said 'Look, we're not trained to do this.' And, but others said 'But this is what's needed and what physical medicine is about – looking after people with disability.' I, of course, felt very much the latter because this wonderful training I'd had in the Air Force that you, you know, you look after people with disabilities, that was the job. And I could see that there were two sides to this but to us in the Services, rehabilitation was the more challenging and what was, what people needed you know. There wasn't, I mean, to be slightly cynical, there wasn't an awful lot you could do with somebody with rheumatoid arthritis, you could certainly give them gold and give them drugs and follow them and so on. But there it was. And you could, certainly the OTs could do a tremendous amount to modify their environment and physios could teach them, but that's, you know, a package. But the departments were flooded with people with head injuries and MS and strokes, you know, that were not being looked after. So, you know, we kept on for years saying 'Look, you mustn't split this off because the patients will suffer. If you take rehabilitation out and make it purely, you know, as it were a medical thing, then who's going to, who's going to look after these people?' And then as you know

eventually the Heberden Society and the rheumatological, and the Physical Medicine BARR[12] people fused to form the British Society for Rheumatology. And the Medical Defence ... the Medical Disability Society was formed in '79, and then that became eventually the British Association of Rehabilitation Medicine.[13]. And now we have a, a specialty of rehabilitation medicine which some of us thought would never happen.

MAM If I can come back to that in more detail, because the emergence of medical rehabilitation as a discipline is a very interesting one, and like all new disciplines no doubt ran across a few rocks on the way.

CWP Oh yes.

MAM But just to sort of complete your career, did you, I'll say retire in inverted commas like most of us, from Stanmore or did you do one more job?

CWP I did one more. But before finishing, I'd like to say that I'd like to pay tribute to a really remarkable man called Lipmann Kessel who was the, inherited Seddon's ... mantle as the professor of orthopaedics. And he again was enormously supportive of me, and when he took over as professor he asked to see everybody, and he asked, you see, 'I want to spend some time with you – see what you do, learn what your ideas are.' So I explained what we did and he said 'Now, you've done brachial plexus. You've got a package. We know what to do, don't we?' you know. 'You know to splint them, you know the, the management, you know the resettlement.' By the way, we had this wonderful resettlement officer, Mr Daniel(?), at Stanmore, which Derrick Brewerton had introduced, another great thing that he did. A man whose sole job was there to get people back to work, and would liase with industry and go into factories and say 'Your man could do that job if you altered that lathe there or raised the height of that, and then he'll be back.' I mean, this was marvellous. And at one time we had three rehabilitation, rehabilitation officers at Stanmore following in Daniel's footsteps. So, he said 'You've got all that set up, you've got a way of looking after these people, and we know that, and you are not going to add an awful lot to that...'

MAM Done that, been there.

CWP '...why don't you do something else?' He said 'You ought to do something new every five years of your, of your career.' He said 'Now, what are you interested in?' And I said 'Well, we're very interested in the pain thing.' And he said 'Well, what about chronic back pain? This place is <u>full</u> of people. We have a problem back unit with ... two full-time surgeons, you know, looking after it – Ernie Kirwan and Mike Sullivan.' Marvellous chaps, you know, who were doing brilliant surgery, sometimes third referrals, and very complicated cases. And he said 'But these people are left with severe pain and all the rest of it, and that's it. The surgeon has said 'There's nothing more I can do for you.' So, he said 'Why don't you develop that?' I said 'Yes, well I've been thinking of that.' So, we formed a, I was an annexe to the problem back unit, and we organised a special system of a, a rehabilitation regime. And that's when we got our clinical psychologist, Karen Fisher(?), appointed, because

[12] The British Association of Rheumatology and Rehabilitation.
[13] Dr Wynn Parry might mean the British Society of Rehabilitation Medicine here.

so much of chronic pain is a matter of helping people to change their behaviour. You can't effect a pain – the nerve cells are buzzing away, nothing as far as we know can do that – but you can at least help people to bring in their central inhibitory pathways, or to learn coping strategies. And she, she developed a system, together with the physios and the OTs, a package to get people, you know, out of the chronic pain state and into activity. And I remember one of the first patients we saw was a lovely girl who'd had nine operations on her back and was utterly derelict, and she came to us and went through this system, and Karen Fisher gave her a programme and all the rest of it. And a year or two later we saw her for follow-up and I said 'How are you?' 'Oh,' she said, 'I've had a baby, I'm holding a job down, I'm full-time active.' But she said 'I've still got the pain, just as bad, but I've got a life.' And we learnt a lot from all that. So we developed this regime which is actually what I then introduced in my final career move which was at the King Edward VII Hospital, Midhurst – which, again, was a wonderful hospital where I had some of the happiest times of my life and was able to introduce this sort of programme, but in, in a general hospital. As you know, Midhurst is a, is a general hospital. A charitable, a private hospital, a charity that had started again as a tuberculosis sanatorium when King Edward, the bearded monarch, had been over to Switzerland and seen what was done there, and came back and said 'There is to be a Switzerland here.' And the King Edward was built. And then, of course, when tuberculosis was knocked, it became a polio and orthopaedics and so on, and now it's expanded into cardio and thoracic and so on. And I was approached towards the end of my time at Stanmore to see whether I would like to come and set a similar thing up there, so I retired a little bit early from Stanmore – about a year early – to do this.

MAM And you were director again...

CWP Director of rehabilitation, yes.

MAM ...of rehabilitation, but primarily to introduce that to...

CWP Yes. So, again I...

MAM You're a real starter, aren't you?

CWP Well, it's fun, isn't it, to, if you can see that something needs doing.

MAM Did you do much the same at Midhurst, the same sort of principles?

CWP I got a, a mini care ward going, yes. Again, I think it was a 16-bed pretty well ... and Mrs Kleinwort(?) who gave a lot of money for this, persuaded by the Duchess of Norfolk who was the patron of the hospital. The Queen is the president, you know – it's a wonderfully patrician organisation and there's nothing wrong with that. It's the happiest place I've ever worked in.

MAM Really?

CWP Oh, you came into work and everybody's smiling, you're welcomed, you know. It's great, the patients absolutely love it and it's lovely to work there and, again, a great team, because what I really like doing is getting a team round and I

suppose...

MAM This seems to be one of your major contributions?

CWP Well, I'm a bit of a catalyst. I hope to try and...

MAM To bring...

CWP ...bring people together...

MAM Yes, and all the necessary skills have to go together...

CWP ...and persuade them, and persuade them they can do it. I remember I was terribly excited in the early days with persuading physiotherapists that they must publish, and they must talk at meetings. And, and of course [I] had my wonderful experience with Burn about how to present a paper or how to write it all paid off dividends. And I used to tell the physios 'Now, you must speak,' and all the rest of it. And I think one of my greatest excitements was the year I was president of the British Society for Surgery of the Hand and was very chuffed because I was the only physician that had been made president of this surgical society. And we introduced the idea of the ... hand therapists joining in, and a prize was set out for the best paper read at the joint meeting, and the best, the prize was won by my physio Vicky Frampton. I think that was one of the most rewarding things that I can remember, that there was this girl who was terrified in the early days to speak, and I said 'Of course you can do it. You know, you're a great girl and you've got a great charisma, and you're very intelligent and you've done all this work. I haven't done it, you must, you must present it.' And of course, once you tell people they can do it, they can do it, you know. Nothing's impossible!

MAM Well, I think there's, you know, a little bit more to it than that, but...

CWP Not much, not much, no.

MAM But now, your interests, personal interests... Presumably Midhurst, where you weren't too long, is that right?

CWP About four years.

MAM Four years. You were really more interested in planting rehabilitation than pursuing your own particular...

CWP Well, no. Well, we got on with, I was happy enough, fortunate enough to work with a man called Mark Mather(?), who was the anaesthetist, who was a leading light in the pain circle, and The Pain Society which I belonged to, and got to know him. And we had, we set up a back unit there and, of course, the population there was rather elderly, and we saw a lot of people with chronic back pain and realised that many of them were having this so-called facet joint syndrome. They were getting osteoarthritis of their facet joints with severe pain often radiating down the leg, but not true sciatica like a disc, but discs are rather rare in older people as you know, and this is common. And so we'd learnt a little bit at Stanmore – one of the anaesthetists

was doing these facet joint injections. But it really took off with Mather because he was very skilful, and did these very beautifully, and so we decided we'd run a trial and we published a couple of papers on, on the value of facet joint injections. And one of our first patients fortunately was Hardy-Roberts[14], who had been the boss-man at the Middlesex Hospital – you know, Major General Hardy-Roberts, a great man. And he was, he came to us with this severe back pain and we gave him the injection, we gave him the intensive ten day package of rehabilitation with twice a day in the pool learning how to live with backache, building up muscle power and all the rest of it. And he totally lost his pain. So we, we were noised abroad all round West Sussex, you know, 'These are the chaps who will get your back pain.' So I think we got a hundred patients that we were able to deal with and... So yes I, you know, it was, it was very active. But it was mostly strokes, back pain – old-fashioned physical medicine you might say – which was what was required there because we've always responded to the need that was there. I don't think one should come into a unit and say 'I want to do so-and-so, I want to study so-and-so.' Say 'Well, what's here, and let's see what we can do.' But there's always something to be done, you know, there's always something.

MAM I think we might break there, Kit, and in the second half I would very much like to discuss with you what you've done now, because I know it's something different. Also, you must have made a major contribution apart from clinical medicine to advising health authorities and the department, and I know you've made a major contribution to the College [Royal College of Physicians]. And I think we should touch on those before we call it a day, because they've all actually had an influence on establishing rehabilitation medicine. So, thank you very much for Part One, I think you've earned a rest.

CWP Thank you.

[14] Brigadier Sir Geoffrey Hardy-Roberts