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CORRESPONDENCE

Correspondents are asked to be brief

Rehabilitation

SIR,—The subject of rehabilitation in and after medical treatment is topical, especially in view of the recent Tunbridge Report[1] in England and the Mair Report[2] in Scotland. The Secretary of State for Social Services, Sir Keith Joseph, has also made a number of pronouncements, and added to this are the announcements of the setting up of at least two professorial chairs in rehabilitation. A number of questions arise, largely because of the apparent move to create a specialty of rehabilitation in certain quarters. The British Council for Rehabilitation of the Disabled is certainly interested and would appreciate representations from any appropriate quarter on the following points:

Rehabilitation, while basically a medical matter, does nowadays more frequently than not become a multidisciplinary exercise. Medical, psychological, educational, vocational, social, and economic factors bring in specialists from their various spheres, who may, lacking knowledge of or communication with other specialties, hinder the patient's progress and even retard it. In the area of medical rehabilitation alone there are different approaches to physical rehabilitation, mental rehabilitation, rehabilitation in geriatrics, and the rehabilitation of children.

Because of the need to approach the "whole man" in his rehabilitation what should the orthopaedic surgeon know, for example, about housing, employment, etc.? What should the psychologist know about, say, educational methods or the neurologist about transport, or the rheumatologist about vocational training, or the physician about economics, or the geriatrician or paediatrician about sociology, or indeed about anything other than the immediate problem related to his own professional skill? Is he not required to lift his eyes and look ahead at the circumstances through which his patient might move in order to assess the relative value of what he is about to prescribe or perform? Of course he is. Then how and by what means is he to know and learn?

The central figure in finding the shortest answer to the problems enumerated above may well be in the rehabilitation consultant envisaged in recent reports and promulgations. How is he to be trained? Is it possible to achieve this superman? Must he be a medical man? Whence would come an individual acceptable to all disciplines as the appropriate person to trigger off the appropriate service at the appropriate time? Where should he be located—at regional or area level, in a teaching hospital, or in one of the new demonstration centres? In other words, how accessible should he be to those dealing face to face with the patient and who may feel in need of his services?

What about training for the role of consultancy in rehabilitation? Should this be on an "in service" basis in which the maximum contact with supplementary and paramedical services is achieved (cross-fertilization)? Where should the seeds of rehabilitation knowledge be sown? In the later undergraduate period or in postgraduate courses for, say, G.P.s and hospital staffs?

Would a short reorientation course for existing consultants in rheumatism and rehabilitation be of immediate value? What should make up a long-term syllabus for future consultants or senior registrars? (see Tunbridge Report, ch. 15, and Mair Report, app. VI). Should medical rehabilitation be a specialty in its own right? Should (or can) rehabilitation be a specialty *tout ensemble*? Is the current linking (presumably on the basis of expediency) of rheumatology and rehabilitation logical and in the best interests of the patient—who might, for example, have a fractured tibia or a head injury?

The role of the Joint Committee on Higher Medical Training cannot be expected to be one of advice on rehabilitation and the Standing Advisory Committee on Rheumatology might not feel competent to advise anyway, notwithstanding the current linking with rehabilitation mentioned above. However, while it may not be the policy of the J.C.H.M.T. to initiate the creation of new specialties, it is possible that if there were a request for an S.A.C. on rehabilitation it might be considered. So whether it be medical rehabilitation or rehabilitation in the fully comprehensive sense, if there is to be consultancy at all, steps must be initiated now in order at least to match development, if not anticipate it, in the reconstructed N.H.S. Chairs in rehabilitation—two are under way in universities—personal chairs, or readerships in the demonstration centres envisaged by the Secretary of State are possibilities for which we should be prepared.—I am, etc.,

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1 Department of Health and Social Security, *Rehabilitation*. London, H.M.S.O., 1972.
2 Scottish Home and Health Department, *Medical Rehabilitation: the Pattern for the Future*. Edinburgh, H.M.S.O., 1972.

Endocardioscopy in Bacterial Endocarditis?

SIR,—Your recent publication (23 June, p. 706 and 30 June, p. 764) of Dr. Graham W. Hayward's Croonian lecture on bacterial (infective) endocarditis, delivered in May 1972, serves to underline the continuing difficulties in diagnosis of this dangerous disease. However, the technical breakthrough described in an article concerning the work of the biomedical engineering department at King's College Hospital (9 December 1972, p. 604) may well be a long-awaited diagnostic improvement in this condition. The 3-mm flexible fibrescope developed at