Return to work

SIR,—The success of treatment for disease and injury should be judged on the social adaptation achieved. Ferguson *et al*¹ in 1954 revealed that nearly one in two patients discharged from medical wards failed to return to work within three months. Twenty years later Blaxter² has found remarkably similarly that nearly one in two patients discharged from hospital with a potentially disabling condition have problems about return to work within the following year, only about half of which are solved. Such facts demand that very careful attention should be paid to any suggestions for improvement of employment rehabilitation services, like those made by Drs D A Brewerton and P J R Nichols (15 October, p 1006). Their criticisms are based on careful observations and indicate that the problems to be tackled are too serious to be left to a small service and to one quite separate from the mainstream of medical and social care.

To consider the employment problems of a patient, as to consider all factors relevant to his rehabilitation, is the duty of every doctor with responsibility for clinical care, whether in general or in specialist practice. Hence to consider the arrangements for such care should be the clear duty of the medical profession as a whole, whether by the royal colleges, research councils, professional societies, universities, or the NHS. It seems a curious fact that several services vital to patient care for those prone to chronic morbidity are organised outside the health authorities, like those for employment rehabilitation, artificial limbs, invalid vehicles, allowances assessment, and aids provision. These services have had remarkably little evaluation of their effectiveness. Seldom has consideration been given to their development by the renowned organisations generally promoting standards of patient care—certainly not of services for employment rehabilitation. There may be dispute about the value of cardiac rehabilitation, but at least there are facts to discuss and forums in which to debate.

While supporting entirely the need for careful review of the employment rehabilitation services and of the inadequacies of its relations with medical services, I advocate that such a review, presumably being undertaken in part already by the Royal Commission on the NHS, should include the administrative linkages and clinical contacts between all the services being provided for the potentially disabled.

One other comment: many other countries now make available vocational counsellors specially trained from the professions providing rehabilitation services—namely, nursing, social work, or remedial therapies. The employment problems of the disabled nowadays are too central to overall patient care for these to be left to anyone not so experienced. To establish the necessary therapeutic relationship basic to modern-day counselling takes a considerable skill, one generally not acquired by a clerical officer. In my opinion, Drs Brewerton and Nichols's recommendations on the future of the disablement resettlement officer service are worthy of support.

The Employment Service Agency (ESA) has a clear responsibility in these matters, in particular its Director of Rehabilitation and Resettlement. To respond to these and other criticisms will take great courage, as cherished ideas and plans are being challenged forth-

rightly. As standards of patient care are involved the medical profession has a clear duty to contribute to solve these problems in whatever way possible. Will the ESA and the Government take action on Drs Brewerton and Nichols's observations, and if not why not? What are the views of the doctors in the Employment Medical Advisory Service?

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¹ Ferguson, T, and MacPhail, A N, *Hospital and Community*. London, Oxford University Press, 1954.

² Blaxter, M, *The Meaning of Disability*. London, Heinemann, 1976.

SIR,—Drs D A Brewerton and P J R Nichols write (15 October, p 1006) of the difficulties of rehabilitation of those with physical disabilities and the deplorable gap between the medical profession and those outside the Health Service.

Disorders with a variable course or a major psychosocial component are not readily understood by people without appropriate training, and arthritis is mentioned first. Mobility is of great value in improving independence for severe rheumatoid arthritis, and a mobility allowance for even a temporary period would make life easier and pleasanter, but it is not always obtainable. Medical supervision could determine the length of the period granted.

Also there are many experienced arthritic drivers who cannot drive an ordinary car but could manage a light automatic car with an adjustable seat for a stiff leg. They do not need the proposed new car for invalid chair patients, but they do need light steering, automatic gears, and special seat adjustment.

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Motorcycle training and accidents

SIR,—On 25 October the Minister of Transport announced a National Saferider Scheme for new motorcycle riders. This is a welcome, albeit overdue, initiative by the Government to try to reduce the ever-increasing numbers of casualties to motorcyclists.

Although the number of casualties has been going up, the actual rate per km travelled has been falling slowly since the introduction of legislation for crash helmets in 1973. It now appears to be becoming more widely accepted that this rate could be considerably reduced by a more systematic programme of training for motorcyclists. It is possible, however, that this new scheme may not achieve the purpose because it is likely to cater mainly for the already converted. Fortunately there is some evidence from Canada¹ to show that the introduction of a national motorcycle training programme does work. In that country the casualty rate peaked in 1968 and has fallen steadily ever since. Training programmes were first started in Ontario in 1967, followed in the early 1970s by other provinces. The schemes remain voluntary at present, but there are moves to make them compulsory on the grounds that the very people needing the training are the ones least likely to come forward.

It is encouraging to note that in its efforts to reduce motorcycle accidents the Government is also taking the initiative on TV to

draw the attention of car drivers to the vulnerability and lack of conspicuity of motorcyclists approaching from the right. If the Government would give this even greater emphasis by more widely encouraging motorcyclists to wear bright clothing and use dipped headlights all the time we would almost certainly see a further reduction in the unnecessarily high accident rates for motorcyclists. Once again it is the high-risk group that fails to take these elementary precautions and there may be no way out of this (since most of their peers drive exotic cars rather than lethal motorcycles) short of legislation.

It may well be that in time legislation will also be required for systematic motorcycle training to be undertaken before going on the road. This could possibly be avoided by all secondary (middle) schools including motorcycle training within their syllabus for all their pupils, male and female. It remains a most extraordinary facet of our permissiveness that we allow inexperienced young people to ride out to such a high chance of serious injury or death without ever giving them basic training before doing so. When mountaineers and hang-gliders do the same thing we soon clamour for a better regulation of their activities.

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¹ Munro, S, *The Role of Licensing and Training in Motor Cycle Safety*. Ottawa, Ministry of Transport, 1974. (Additional up-to-date information supplied in personal communication.)

Treatment of cerebral abscesses

SIR,—We write to correct the misleading and potentially dangerous tenor of your leading article (15 October, p 978). The myth of sterile abscesses having been destroyed, it seems likely that a more dangerous myth alleging the predominance of anaerobic microbes, in particular bacteroides, will arise. This is based not on evidence but on conjecture and on misunderstanding of our report.¹

The predominating microbes in brain abscesses are streptococci, isolated from 78% of patients; 40% yield *Streptococcus milleri*, Lancefield Group F, Ottens and Winkler type O III. These organisms of the viridans group are not anaerobic streptococci. Peptostreptococci are isolated occasionally. You err in alluding to an apparent predominance of *Bacteroides fragilis*. In company with streptococci, enterobacteriaceae, and other microbes, this anaerobe is isolated almost invariably from otogenic abscesses,^{2,3} sometimes from those of sinusitic origin, but rarely from abscesses of other types. Very great care was taken in our study to establish this point. The pus was inoculated into thioglycollate medium in the operating theatre without delay. Nalidixic acid agar was used invariably as a selective medium, and, moreover, the pus itself was analysed by gas liquid chromatography for the presence of fatty acids indicative of anaerobic bacteria. Six of 11 isolates of bacteroides were clustered in the group of temporal lobe abscesses of otitic origin, emphasising that it is in this type of abscess that the microbe is to be expected. Your leading article, while ostensibly dealing with the treatment of cerebral abscesses, actually concentrates on the treatment of otogenic abscesses and fails entirely to discuss the

treatment of abscesses of different aetiology, with which we dealt in our second report.³ We regard this omission as dangerous.

Your preoccupation with a single chemotherapeutic agent, effective only against strict anaerobes, is misleading, since we have demonstrated that aerobic and microaerophilic organisms predominate in cerebral abscesses. Of the patients in our study, 76% were infected only with microbes that were demonstrably resistant to metronidazole. Further, we remind you that lincomycin and chloramphenicol are effective against anaerobic bacteria and that they were used in the treatment of some abscesses in both series of cases discussed in the leading article. Carbenicillin, not used in either series, and fusidic acid also have some activity against anaerobic bacteria.

The treatment of cerebral abscesses is primarily surgical and it remains so. Rapid and accurate location of the lesion followed by prompt evacuation of the pus and internal decompression continues to save lives. Factors other than the choice of antibiotics, such as measures taken against cerebral oedema, should be taken into account in any discussion of mortality.

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¹ de Louvois, J, Gortvai, P, and Hurley, R, *British Medical Journal*, 1977, 2, 981.

² Ingham, H R, Selkon, J B, and Roxby, C M, *British Medical Journal*, 1977, 2, 991.

³ de Louvois, J, Gortvai, P, and Hurley, R, *British Medical Journal*, 1977, 2, 985.

Polio immunisation in pregnancy

SIR,—To your expert (Any Questions?, 23 July, p 244) it is clearly sensible to use the opportunity of antenatal contact to immunise non-immune mothers against poliomyelitis. As recently as March of this year, however, the Joint Committee on Vaccination and Immunisation¹ stated that "live vaccines should not be administered to pregnant women, particularly early in pregnancy, because of possible harm to the fetus. However, where there is a significant risk of exposure to such serious conditions as poliomyelitis or yellow fever the importance of vaccination may outweigh the possible risk to the fetus." Attention to this general contra-indication is drawn again in the section of the same report specifically dealing with poliomyelitis.

Many doctors will instinctively feel that the more cautious approach of the joint committee is the wiser policy. It has been said that the best obstetrician is the one who keeps his hands longest in his pockets.

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¹ Note by Joint Committee on Vaccination and Immunisation. Appendix to CMO(77)7/CNO (77)3. London, DHSS, March 1977.

* * * Our expert replies: "My answer was to a question from Iraq, which was not made clear in the printed question but should have been. The Joint Committee on Vaccination and Immunisation provides national and not

international guidelines, although they do say, as Dr Twomey quotes, that vaccination during pregnancy may be justified 'where there is a significant risk of exposure to . . . poliomyelitis.' I therefore stand firmly by my view in the Iraqi context." We regret our omission to indicate the place of origin of the question and apologise to our expert and to readers for any misunderstanding that this may have caused.—Ed, *BMJ*.

Plight of Maltese medical students

SIR,—With reference to the comments by Scrutator on the position of Maltese medical students (15 October, p 1036) I must point out that the impasse the final-year medical students found themselves in when they were left with their examinations not completed was precipitated by the Medical Association of Malta when it decided to take industrial action fully aware that the examinations would have been completed had their action been delayed by just two more days and also fully aware at the time of the repercussions that would result therefrom.

The Government was in no way responsible for that situation, as, in the interest of the patients, it could not discriminate between consultants who refused to give an emergency service as required from them by the Government from those same consultants who, as examiners, insisted that they be admitted to hospital to select patients for clinical examinations. In this connection it is also to be borne in mind that at the time only emergency cases were being treated in Government hospitals and the Government was not therefore in a position to allow patients to be used for clinical examination purposes when their care and treatment were its primary consideration.

Besides, the examiners did not even have the decency to give advance notice when they would be using the hospital. They just appeared at the hospital doors and demanded admittance. Such arrogance could not be tolerated and was moreover interpreted as being intended to place the authorities in a position where they could not accede to the examiners' request.

The students, other than those in their final year, who chose to leave Malta did so despite the Government's promise that the medical school would be reopened, as it did on Monday, 17 October.

The fact that "Britain is still a democracy" does not give the right to any group of Britishers to interfere in the internal affairs of any other Commonwealth country. It is high time for these Colonels Blimp to accept the fact that Malta is no longer a British colony.

Lastly, it is more deplorable and it betrays a large measure of bias for Scrutator to conclude that the present dispute "seems bound to affect the standard of medical services." Not only have the previous standards been maintained but also the medical services being provided at present have been extended to include operations which before were never performed in Malta.

TONI PELLEGRINI
Director of Information

Office of the Prime Minister,
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* * * The Secretary writes: "Information reaching the BMA conflicts strongly with several of Mr Pellegrini's statements and sheds a very different light on the state of affairs in Malta as described by him.

"(1) None of the Malta doctors have refused to treat emergencies. The MAM has published advertisements in the press telling the people of Malta that they stand ready to treat emergencies in any hospital, public or private. This has been the position from the start. Unfortunately the Government reacted by locking doctors out of the hospitals, and those who attempted to remain were ejected by the police.

"(2) Dates when examinations are to be held are arranged a long time in advance and the Government therefore had plenty of notice of these dates. Nevertheless the examiners, including external examiners who had travelled from Britain, were refused admission to the hospital for purposes of conducting the examination.

"(3) As nearly all the clinical teaching staff have been dismissed by the Government it is impossible to see how clinical training can be conducted properly. The Maltese Minister of Health met the students on the evening of 15 October in order to tell them that the medical school would be reopened on 17 October. The students asked for the names of those who would teach them and they were not given a single name.

"(4) It is stated that the imported doctors staffing the hospitals at the time of the examinations were dealing only with emergencies. In fact they were dealing with 'cold' cases as well as with emergencies."—Ed, *BMJ*.

Dispute in Malta

SIR,—May I add my voice in support of Mr L J German, of the Medical Association of Malta (22 October, p 1082)? The struggle of our colleagues on that island is now against what is probably the ultimate threat to professional independence, a government that regards judgment of competence to practise as made better on political than on professional grounds. The Maltese Government has not only sought to dominate the profession by withdrawing their legal right to practise but has even added a quite monstrous denial of hard-earned pension rights. There are lessons in this, sir, for all of us. The independence of our profession must be fought for wherever it is challenged and I am happy to support Dr J A Cameron's appeal for funds (10 September, p 708).

Publicity is essential. We should be warning our patients personally, through the press and through travel agents, that a medical emergency to a tourist in Malta will no longer be managed by the local men for whose competence we in Britain have so often been able to vouch. Instead they will be in the care of doctors chosen on political grounds from Libya, Czechoslovakia, the Palestine Liberation Organisation, and Pakistan. Few if any of these will have reached professional standards of which we have knowledge or can approve. We should also surely be re-examining the arrangements for the treatment of selected Maltese patients under the NHS here so long as this duress continues.

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Vitamin B₁₂ deficiency in a child

SIR,—I think it is up to me to respond to Dr R Ferguson's criticism (22 October, p 1086) of our paper (24 September, p 807), since the question of jejunal biopsy was dis-