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