Sir John Walton's rider "only when existing clinical pressures are relieved" (24 October, p 1012).

Neurological disorders account for most cases of severe disability, particularly in those patients who require prolonged help. Medical leadership is required to develop the services in every district and region, and to allocate patients with appropriate clinical priority, including allocation to rehabilitation facilities based in the community. There is a role for every neurologist in responding to the challenge. Considerably improved and simpler investigative procedures should make it possible for them to devote more of their time to rehabilitation.

Disabled patients should not be asked to wait for help until new resources can be funded. Neurologists should look now at the distribution resources available for their responsibilities, and see whether their services could be improved by deploying them differently. When a neurologist (or a neurosurgeon for that matter) becomes responsible for a rehabilitation service despair can turn to hope for many patients—which, I can testify, has occurred in Edinburgh. It is up to neurologists to press for the necessary facilities and staff to become available for managing neurological disability. Sir John Walton wrote that "neurologists are prepared to participate fully." It is now the time for words to become action throughout Britain.

CAIRNS AITKEN

Rehabilitation Studies Unit,
University of Edinburgh,
Edinburgh EH10 7ED

SIR,—The Association of British Neurologists (24 October, p 1012) is to be congratulated in acknowledging the lead its members should be taking in managing neurological disability. "Restoration from patient to person," however, does not depend on the provision of regional rehabilitation units. It relates to doctors' attitudes and understanding of the nature of medical practice.

Making time to listen to individuals' concerns preserves their dignity and enables doctors to identify areas of environmental, physical, psychological, and social difficulty that may be helped by the caring professions. Thus intervening in the disease process may be only a small part of the help that medicine can provide. The Medical Disability Society discussed the implications of this for medical education in 1985, when representatives from many medical schools in the United Kingdom agreed that these important attitudes must be taught in both undergraduate and postgraduate curriculums. Minerva summarised it impeccably as "incurable does not mean unhelpable."[1]

The inadequate distribution of rehabilitation facilities throughout Britain reflects the inadequate emphasis given by our profession to the rehabilitative aspects of medical care. Where good leadership was given, as in Oxford or Salisbury, for instance, comprehensive services were developed. Such services are costly. Regional units such as those recommended by the Royal College of Physicians[2] require a multiprofessional team to provide integrated rehabilitation programmes, which have been shown to increase independence.[3] They also need extensive facilities—for example, heavy workshops for industrial therapy.[4]

The Nuffield Rehabilitation Centre at Odstock Hospital was for many years funded solely by Salisbury Health District. An analysis of the larger treatment categories is shown in the table.[5] Neurological conditions were the most time consuming to treat. Although half of new referrals to the unit came from other health districts, more than half the patients with severe neurological disability came from other districts.

*Primary reason for referral, duration of treatment per patient (weeks), and patient source*

| Reason for admission | No of patients | % From Salisbury | Ratio |
|---|---|---|---|
| Neurological: | | | |
| Spinal injury | 6 | 17 | 15·67 |
| Head injury | 13 | 15 | 10·08 |
| Hemiplegia (not head injury) | 26 | 50 | 7·58 |
| Other neurological lesions | 12 | 25 | 5·25 |
| Musculoskeletal: | | | |
| Fractures not otherwise quoted | 9 | 56 | 4·44 |
| Low back pain | 50 | 62 | 4·04 |
| Cervical spondylosis | 11 | 73 | 3·66 |
| Hand lesions | 18 | 39 | 3·17 |
| Rheumatoid disease | 14 | 71 | 3·14 |

Costs of intensive rehabilitation will not be recouped by cross boundary flows.[6] I believe that it is cost that has usually prevented the development of the services that both the Royal College of Physicians and the Association of British Neurologists believe are necessary. If these facilities are to be provided "top sliced" regional funding will be required.

A O FRANK

Northwick Park Hospital,
Middlesex HA1 3UJ

1 Minerva. *Br Med J* 1985;**291**:1134.
2 Royal College of Physicians of London. Medical disability in 1986 and beyond. *J R Coll Physicians Lond* 1986;**20**:160-94.
3 Smith DS, Goldenberg E, Ashburn A, *et al.* Remedial therapy after stroke: a randomised controlled trial. *Br Med J* 1981; **282**:517-20.
4 Frank AO, Henshaw DJ, Parkin DR. Industrial therapy for physical disability in a district hospital rehabilitation unit. *Care, Science and Practice* 1987;5:29-33.
5 Frank AO. Rehabilitation unit: where do our patients come from? *Salisbury Med Bull* 1978;**34**:294-303.
6 Smith J. RAWP revisited. *Br Med J* 1987;**295**:1015.

## Gender reassignment today

SIR,—I hope that Dr Charles Mate-Kole and colleagues (17 October, p 997) will not mind me pointing out that their contact with gender reassignment is a rather recent development and therefore it would be unfair to expect them to have any knowledge of the long term results. Professor Hirsch is known for his contributions to the study of suicide, and it is interesting that the study does not include any comment on suicide rates. It is well documented that gender reassignment surgery does not change suicide rates in these sad people.

Far from gender reassignment surgery being a "recent development," it has been a well established surgical technique for nearly 20 years, and I certainly remember showing a film on the technicalities of this procedure at the section of urology at the Royal Society of Medicine almost 18 years ago.

They are quite right that I am unaware of their recent study. I was not even invited to attend their meeting. Had I been there my views might have poured some cold water on their study. This study claims to be a randomised trial of 40 patients but its statistical validity is open to question. In fact, it does not have controls in it. All it does is to compare delay from presentation to surgery. A control group would mean that there should be a group of patients who had no surgery performed at all, or there should have been a control group where 20 cases of surgical procedures were performed for something totally different. However, to compare this study with 150 retrospective cases is to make a nonsense of the word "academic."

I saw Dr Robin's paper only when it was in draft form and remember sending it back to him, pointing out that it was not a scientific study but a narrative of the feelings of the patients. All Dr Robin's study showed was that some of the patients felt better; what it did not study were those who felt worse.

I am pleased to see that since I first protested to the general manager of the Riverside Health Authority about the continuation of this study, quoting the lack of screening for sexually transmitted diseases, this defect has apparently been put right, but the gender identity team should at least state the incidence of hepatitis B antigenaemia or antibody state and compare it with the normal population if its remark is to have any meaning. It certainly raises a large question over the homosexual state of these patients, because one has to wonder how else they got their antigenaemia.

At the time of writing this letter I have over 250 patients on my urological waiting list, including patients with bladder tumours, either for initial assessment or for follow up cystoscopy, and patients with prostatism who are likely to go into retention of urine before they can be admitted. Delay in treatment in either of these cases increases morbidity and mortality. There is also a small group of patients requiring vasovasostomies because their original marriage broke up and they have remarried and want their vasectomies reversed. Their misery is considerable as some of them have been on the waiting list for two years.

This week seven patients have been admitted for urological surgery and been sent home because there were no beds for operating lists, but the 26 bed urological ward has two gender reassignment patients in it, despite undertakings from the management that the urological bed complement would not be reduced. One gender reassignment operation takes the whole of one afternoon in the operating theatre. During that time, I could perform 10 cystoscopies or resect four prostates or do three vasovasostomies.

Most people would feel that to pursue gender reassignment surgery in the current climate must be bottom of the list of medical importance. The hospital continues with this, although it is totally against the wishes of the division of surgery.

It will be interesting to see how many patients have to go into retention of urine, how many patients have delay in their treatment for bladder tumours, and how many patients—dare we say—die before the management reconsiders its priorities.

GRANT WILLIAMS

Department of Urology,
Charing Cross Hospital,
London W6 8RF

## Doctors and rubella

SIR,—As the National Rubella Week, 22 to 28 November 1987, approaches is it not time for members of the medical profession to put their own house in order? Doctors both male and female should know their own rubella state and if this is negative they should be immunised against the disease.

All doctors, especially those in general practice, obstetrics, and paediatrics, come into contact with pregnant women during the course of their work. If the doctor catches rubella then he or she may put these women at risk.

In a perfect world all girls between the ages of 10 and 13 years would have been vaccinated and before their pregnancy would have undergone a blood test to check their antibodies, but we know that some girls slip through the net and are not immunised. We also know that congenital rubella is still occurring.

All health workers should be protected against