CORRESPONDENCE

Correspondents are asked to be brief

Planning for Disaster in a Rural Area

SIR,—I was interested in your leading article (1 July, p. 3) The rural area with which I am concerned is in a peninsula and is approximately 50 miles (80 km) long and in parts about 10 miles (16 km) wide. The receiving hospital lies near the geographical centre while the supporting hospital is towards one end. The major roads and railways, so often the site of such incidents, lie in the long axis. The distances thus involved, the calibre of the roads, and the traffic density create special problems and necessitate a broad application of the recommendations in HM (54) 51.

Our plan is based on the minimum services available which can be guaranteed at all times, without seriously depleting the designated hospitals of surgical expertise. We believe that clinical assessment is best carried out in the relative peace of the reception areas of the designated hospitals, and our plan is based on total evacuation of all live casualties to these hospitals. At the same time, early arrival of a mobile team is of paramount importance, even if of only limited capability. Though a major mobile theatre has been planned and equipped, our first endeavour is to send a mobile team, headed by a general practitioner from near the "scene."

For this purpose the area has been divided into "zones." Each zone is related to a zone hospital. The zone hospital may be of any size (more often a general-practitioner hospital) and only qualifies for this designation if it can undertake at all times to send out three nurses instantly to an incident in its zone. On receiving a call from the ambulance or police or fire authorities the accident officer on duty at the designated receiving hospital telephones all general practitioners resident in the affected zone. The first found is automatically the leader of the mobile team and will be in administrative charge of on-site medical arrangements for the evacuation of the injured. He collects the three nurses and two rucksacks from the zone hospital and, conveying these in his own car, is given a police escort from the zone hospital to the scene. He can be reinforced by similar teams, despatched from neighbouring zones.

In a recent practice of the scheme the team arrived at a scene, 12 miles (20 km) from the zone hospital, 30 minutes after a telephone call to the police. With land transport, an improvement on this seems unlikely.

It would be interesting to hear how other rural areas have planned to meet their geographical difficulties.—I am, etc.,

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Rehabilitation Services

SIR,—Your timely leading article (24 June, p. 727), which rightly draws attention to the need to establish effective rehabilitation services, refers to "physical medicine" without qualification. This term is a great source of confusion. Introduced at a time when it was hoped that "physical" methods (particularly electrical techniques) would prove effective in the treatment of locomotor disorders, it has outlived its usefulness. In the U.S.A. such a purely therapeutic specialty does exist—"physiatry"—a state of affairs which no one wishes to see in Britain. More recently "physical medicine" has been taken to indicate a specialty with a range of responsibility spanning rheumatology, "medical orthopaedics," rehabilitation, and administrative responsibility for the ancillary services of physiotherapy and occupational therapy. A case can be made for this (many N.H.S. consultant appointments still carry such responsibility), but it is undesirable for a number of reasons and the changing titles of many departments previously designated physical medicine bear witness to the fact that this is the view of those actually practising this specialty. Rheumatology is a branch of general medicine and, while it covers a wide range of diseases, from backache and stiff shoulders to exotic connective tissue disorders, it is only one of a variety of specialties which may provide "medical cover" for the ancillary remedial services, and it is only one of many specialties from which doctors may be recruited to undertake the extra training needed to equip them to be consultants in rehabilitation.

Awareness of the urgent need for effective rehabilitation services will not in itself solve the difficult problems of recruiting and training competent specialists in rehabilitative medicine, but at least we can avoid the disaster of having the new specialty saddled with the name physical medicine.—I am, etc.,

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SIR,—In your leading article on the report of the Tunbridge Committee on rehabilitation[1] (24 June, p. 727) you rightly begin with the fact that there is a low level of interest in the subject among doctors. The report is full of clear and relevant facts which should be the concern of all doctors. Sir Ronald Tunbridge chaired a special committee of the British Medical Association on rehabilitation and that committee's report was published in 1954.[2] In the 18 years since then the level of interest among doctors has not increased greatly.

There seem to be at least three grounds for fearing that the current report will be ignored by doctors. Firstly, the 1972 report relies on the traditional solution of creating another type of specialist, named a consultant, in every district general hospital. In itself this may induce resistance from doctors