

## **THE NEED FOR NEW SHO POSTS IN REHABILITATION MEDICINE and THE SHO CORE CURRICULUM**

The RCP is to be congratulated on the new SHO Core Curriculum.

There is a problem in recruiting into Rehabilitation Medicine at the Specialist Registrar grade as few SHOs know what goes on in specialist rehabilitation units.

In my own hospital at the last college visit, the main request of the SHOS, besides an improvement in the food was to have more teaching in Rehabilitation!

The Core curriculum is divided into 5 sections: Generic skills, Core Skills, Selection and interpretation of results, Practical procedures, and Additional topics in the specialties.

The **Generic skills** section can be covered particularly expertly in Rehabilitation Units. Eliciting histories from cognitively impaired patients, breaking bad news, communication with colleagues and families in family meetings, and working in an interdisciplinary team, working with agencies other than hospital staff, such as social services and housing are well covered. Legal issues such as court of protection, power of attorney, mental health act and driving issues are all covered. Maintaining good medical practice would be well covered. The seminal paper on “Do Stroke Units save lives?” was possible with the evaluations done in the individual units forming part of the meta-analysis. Rehabilitation has already produced guidelines for inpatient rehabilitation, and for the use of botulinum toxin. Although basic life support would be covered in any induction programme, it would be expected that SHOs entering rehabilitation would have plenty experience of this from earlier jobs.

The **Core Skills** section dedicated to Rehabilitation Medicine needs to be upgraded. The WHO model of rehabilitation now uses the term “Participation” rather than handicap, and disability is replaced by activities of daily living.

It is surprising how much of the **Core Skills** section for other specialties would be amply covered in Rehabilitation Medicine. As stroke is one of the commonest admission to rehabilitation units, it is not surprising that there will be ample opportunity to learn about the management of hypertension, diabetes, dyslipidaemia, and secondary stroke prevention.

Few diseases get a specific mention in the core skill section, but those that are such as deterioration in MS, Parkinson’s disease are covered in Rehabilitation Medicine. Multidisciplinary Parkinson’s clinics are run by some rehabilitation physicians, and figures of 350 attendances a year in Rehabilitation OPD for MS will provide adequate experience of this disease and hopefully a multidisciplinary approach to it. Discharge planning, nutrition, continence, bowel management, pressure sore management, dementia screening, management of DVT, urinary tract septicaemia, and MRSA will be amply covered.

Most of the core skills in neurology will be covered such as Glasgow coma score, epilepsy (10% of Total Anterior artery thrombosis cases have delayed onset of seizures usually when in rehabilitation). Indeed most of the additional topics in the specialty of neurology will be covered on a rehabilitation Unit.

It is regrettable that there is no “**Additional section**” for rehabilitation medicine as there are ample opportunities to learn about ankle foot orthoses, wheelchairs, environmental control

and communication aids. Physicians in rehabilitation Medicine are often encountering unmet need for such devices and this is mainly because other specialities are not aware of their availability.

In “**the selection and interpretation of results section**”, thrombophilia screening , echo, 24 hour heart monitoring, carotid ultrasounds, bladder ultrasounds, dexta scan indications, and CT scan and MRI indications will be covered.

In the “**Practical Procedures Section**” management of tracheostomies, and common procedures such as knee aspiration will be covered. Botulinum toxin injections and the indications for them could also form part of an additional section in future upgrades of the Core curriculum.

Obviously, the key areas not covered during an SHO job in rehabilitation will relate to leading a cardiac arrest team and management of “The Take”. However, many care of the elderly physicians who are involved in elderly care stroke units also manage the take, and also because of multiple pathology in the elderly will be able to cover some of the more acute requirements such as renal and cardiac disease.

The ideal arrangement would be a rotating SHO job between Specialist rehabilitation Units and Care of the Elderly Rehabilitation with “Take” experience.

There is nothing in the Criteria for Dean’s approval of SHO jobs which would not be achievable on rehabilitation Units. Most have practiced Induction, education plans and appraisal for some time. Indeed some do multidisciplinary appraisal!

In summary, the new Core Curriculum for SHOs can be covered to a considerable extent by new posts in rehabilitation Medicine. In addition, many people with unusual physical signs such as those with Hereditary Sensory neuropathies, muscular dystrophy, spinal muscular atrophy, besides those with common diseases such as MS, Parkinsons disease and Polio provide a rich source of clinical teaching for MRCP.

Although we would hope that new SHO posts in Rehabilitation Medicine will lead to an increase in dynamic recruits to the specialist registrars posts in Rehabilitation Medicine, we would also have the satisfaction of knowing that any GP, Care of the Elderly physician , or neurologist, who had done an SHO job in Rehabilitation would have acquired many rehabilitation skills and be a better team player as a result of their time in Rehabilitation Medicine.

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