THE NEW DIPLOMA IN MEDICAL REHABILITATION

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My Lord Chairman, for some years the Conjoint Examining Board in England have held a Diploma in Physical Medicine, and over the years the Diploma has attracted a small number of candidates each year, ranging from two, to two dozen, both from this country and from overseas. In recent years the term “Physical Medicine” has become increasingly obsolete; first of all the British Association of Physical Medicine changed its name to Rheumatology and Rehabilitation, the section of the Royal Society of Medicine has changed its name and the Advisory Committees at the Royal College have changed their name, and there has been a marriage of sorts between rheumatology and rehabilitation. Taking cognizance of this, the Examining Board and the Royal Colleges together rethought their situation with regard to the Diploma in Physical Medicine, and they consequently, as we all do in these circumstances, set up a committee, which deliberated over a period of time as to what to do about it; and in the event they have borne forth a new Diploma to be called “The Diploma in Medical Rehabilitation”, and the first examination will take place some time in 1976 – the reason for that is given below.

This new Diploma has slightly different objectives from those of the old one, and although its aim is still to assess a candidate’s understanding of the principles of rehabilitation for all types of physical disability, including methods of returning the disabled patients to society, and as there are many aspects of rehabilitation, and as it is already a major aspect of some specialties the revised examination is going to be in two parts.

The first section will be a general one concerned with the underlying anatomy, physiology and pathology of locomotor disorders, with the principles and practice of rehabilitation, and will require a knowledge of the organisation of rehabilitation departments services. The second part of the examination will be concerned with special clinical topics on which a candidate must offer one subject for examination; and, for these reasons the precise training for the revised Diploma cannot be so easily defined as it was previously, as it will depend a great deal on the candidates total experience after qualifying, and his particular special interest that he is nominating for examination, and while considerable experience in general medicine, and the adequate back-up experience in orthopaedics and neurology is essential the requirements for the individual specialties will obviously be different.

The examination will be in two parts. The first part a general one – which will include written, oral and clinical aspects – but in the special subject it is suggested that this will be in the presentation of 12 case histories with commentaries, or, as a dissertation on a special clinical study, and the candidates will have to nominate this special subject, and they will have to have accepted by the examining board their programme of training, which it is expected will last two years. The subjects which have been selected were done in relation to the sort of special interests which people in rehabilitation have evinced over the years, and they include paediatric rehabilitation, injury and disease of bones and joints, which is the rheumatological side of it, spinal cord lesions, and a large number of people in rehabilitation, particularly from overseas derive their interests, and practise much of their time, in spinal injury units, prosthetics and orthotics, a subject which I feel many of you will think has been neglected in the past, and has had little academic incentive to improve it. Geriatrics, which again in this country is rapidly enveloping vast resources for rehabilitation both in hospitals and in the community. Neurological rehabilitation a field that I am sure many will regard as having been neglected by our neurologists in the past. Cardiorespiratory disease, and last, but by no manner least in this audience a title, which is given “Medicine in Sport and Recreation” and this will include, it is envisaged, the physiology of exercise, the medical aspects of hazards of sports and recreational activities, and the prevention and treatment of sports injuries. I hope that this definition will cover the interest of this audience.

There are one or two specific points about the Diploma, which I think I ought to make, firstly because of this radical change in approach – the old concepts of having recognised departments for training will disappear. It is the training programme that is being recognised, not the department in which the man is working. That is to say that it will need to be tailored individually and accepted for each candidate depending on his general experience on the one hand, and his special interest on the other. The second point is that the Diploma is not considered, as was not the previous Diploma of Physical Medicine, a short cut to becoming a consultant in this country. It is designed to cater for special interests, of those people whose broad interests may very well lie within the very broad canvass of rehabilitation. In many of the subjects it will be particularly relevant to the general practitioner clinical
assistant. It will be particularly relevant to overseas post graduates coming into this country, and for the others in rehabilitation in this country, will very largely be a declaration of particular special interest.

One last point that I would like to make, and to echo, the first speaker, and say that as the adviser in this training programme, and as adviser to the Examining Board, one will be looking for help, and advice, from each individual group, concerned with each individual

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tal Training

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When we contemplated joining the European Economic Community it was clear that there were widely differing standards for specialist recognition and methods of assessment in the member states. In their wisdom the Royal Colleges of Physicians and Surgeons in the United Kingdom and Eire set up joint committees on higher medical and higher surgical training to evolve uniform standards for training and to plan for specialist accreditation. These parent bodies spawned specialist advisory committees whose duty it is to produce training programmes, to update them as necessary to keep pace with changing trends, and to visit training posts in order to determine whether they are suitable for the purpose thus defined. This policy is already producing a salutory impact on the standards demanded of higher specialist training jobs at Senior Registrar level; no units are sacrosanct, however venerable the institution or the individual trainer may be, and it is highly significant that to date of all the posts visited within the remit of the Joint Committee on Higher Medical Training only a handful has been unreservedly recommended. We recognise, and indeed hope, that an element of blackmail is implicit in this arrangement since senior registrars are unlikely to waste their time applying for or remaining in a post which is not recognized. Provisional recognition for a limited period may be a useful means for ensuring that merely adequate posts are improved by encouraging employing authorities to provide additional facilities or manpower.

The training programmes of the Joint Committees are readily obtainable from the Royal Colleges, and should be studied carefully by all intending higher trainees. The point that both the reports of these Joint Committees make are first, in common ground, that these will not be rigid and inflexible guidelines laid down on training programmes. The second thing that one must make clear is that specialist accreditation at the end of a training period is not synonymous with specialist registration which may or may not in due course become a function of the General Medical Council. The Joint Committee on Higher Surgical Training is not preparing ‘to arrogate to itself the power either to direct trainees into specific posts, or to usurp the right of appointing bodies to select their own candidates.’ Either of these things would be unthinkable.

The aims of the Joint Committee and its specialist advisory committees, which are very much the aims of the Joint Committee on Higher Medical Training, are firstly to designate, after proper consultation and collaboration with regional postgraduate committees and other regional authorities, those specialist training posts that are regarded as providing the proper degree of experience and opportunity for study or research that a potential consultant requires. Secondly, to establish a continuing relationship through his consultants and teachers with each individual trainee specialist throughout his period of higher specialist training. I think it is not recognised generally that the specialist advisory committees of these two Joint Committees are there to give advice right the way through. I have been a member of the Specialist Advisory Committee on Rheumatology since its inception in 1971 and I can only recall one or two people writing to the committee for advice. So this is clearly something which has not made sufficient impact.

Finally, the object of the Joint Committees is to

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