Editorial

The trouble with brain injury

"The trouble with head injury is that it isn't cuddly," to quote Kate Field's article (p 217)¹ and plea for better head injury services. And this is true not only of head injury. Whether due to stroke, multiple sclerosis, or any other cause, cognitive damage which results in personality and behavioural problems creates a nightmare for any family, who have not only lost someone they love but are obliged to take on a stranger in their place – often not a very pleasant stranger at that.

I am sometimes surprised by the uncomplaining acceptance of this burden. Sadly, the commonest reaction among medical colleagues is to heave a sigh of relief and plan an early discharge date. When community care breaks down, as it almost certainly will, there is at least a sporting chance that the patient will be admitted somewhere else.

Effective rehabilitation is cost effective. It can increase independence and reduce care needs, complications, and readmission rates – quite apart from any improvement of quality of life for patient and carer. Computed over a patient's lifetime, the savings in continued care offset many times the cost of rehabilitation. But there is a hitch. Health care pays for the rehabilitation, while the benefit of reduced care costs accrues to the social services. Joint commissioning must be the answer, but is proving very slow in gestation.

Meanwhile, how do we ensure that rehabilitation is effective? Effective management of cognitive and behavioural problems requires the coordinated effort of a specialist multidisciplinary team. Not every patient needs this level of service, but when he or she does it is often hard to persuade purchasers to pay for it. Many purchasers would prefer to develop their own services

locally or in the community, but it is very rare for these services to be able to provide the necessary level of skill and experience – there are simply not enough appropriately trained therapists. Whether they work in hospital or community settings, specialist teams take time to build. They cannot be picked off a shelf and returned at a whim. Short term contracts, negotiated year by year, do not allow the stable development of a highly skilled team. The demise of the regional health authorities threatens the existence of specialist brain injury units, many of which have had at least partial top sliced regional funding. Their survival is essential, not only for their specialist skills and experience but also as a focus for the training and research that is vital to the future development of rehabilitation.

Under pressure, short term financial considerations are apt to take precedence over long term planning, but before we opt for any cheap alternatives it is important that we capitalise on existing resources. Maximal cost efficiency demands a critical mass of senior staff and training grades, and this in turn demands a sufficient caseload. Linking outreach or day facilities to existing inpatient services may allow this critical mass to be reached and thus serve the dual purpose of training tomorrow's staff and containing today's costs.

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1 Field K. The game of injury hop-scotch, UK style. *Quality in Health Care* 1994;3:217–20.

Keyword indexing: brief guidance for authors

From 1994 onwards the method of compiling the subject index in *Quality in Health Care* will change, whereby papers will be indexed by a keyword system. Authors of papers are requested to include up to three, occasionally four, keywords (words or phrases identifying the subject) on their manuscript, which will contribute to the compilation of the annual index in the December issue. The subject index will be different, with the title of the paper repeated after each keyword for every entry; cross references will not appear in the subject index. The author index will no longer include the title of the paper and will comprise a list of authors and page numbers only.

Choosing keywords may not seem intrinsically difficult, but there are unforeseen problems. An index should be as consistent as possible, and entries should not be split between, for example, "antenatal care" and "care, antenatal." Whereas some decisions may reasonably be made about the entries that can be predicted, authors will not know

what other work is being published in the same volume or under what titles. Therefore, some modifications by the technical editor may be necessary.

General points

Authors should scan their paper for keywords that may not be in the title, use British approved names for drugs rather than proprietary names, and avoid general terms such as clinical, complications, adverse effects, and patient. As the subjects of the journal are "quality" and "health" it would be better to avoid these terms as keywords whenever possible. Retaining accepted phrases and concepts is preferable – for instance, "health district" rather than "district, health". Some shortened forms may be acceptable as keywords – AIDS, HIV, GP, TQM are widely known and understood – but generally the full form of abbreviations should be used.

Within this framework authors are encouraged to consider their choice of keywords carefully to facilitate location of their published work by readers.