

The Dream of a Medical Specialty Named Physical and Rehabilitation Medicine

A Commentary on the European White Book of Physical and Rehabilitation Medicine

Ebenbichler G¹, Resch KL²

¹Department of Physical Medicine and Rehabilitation, Medical University of Vienna, Währinger Gürtel, Vienna, Austria

²German Institute of Health Research, Bad Elster, Germany

Nachdruck mit freundlicher Erlaubnis des American Journal of Physical Medicine and Rehabilitation

Originaltitel: Ebenbichler G, Resch KL: The dream of a medical specialty named Physical and Rehabilitation Medicine: A commentary on the European White Book of Physical and Rehabilitation Medicine. *Am J Phys Med Rehabil.* 2009 Feb; 88(2):165-7

A proposal has been made concerning an innovative concept for a medical specialty called Physical and Rehabilitation Medicine (PRM). A board of European-recognized “physiatrists” has revised the White Book (WB) of PRM published in 1989 taking into account continuously changing needs and demands in patients’ medical care. This revised version of the WB[1] describes the foundations of rehabilitation and mirrors the European view of the PRM specialty by highlighting the conditions treated, its diagnostic tools, the assessment process, and the interventions and treatments used by PRM specialists, as well as the training of PRM residencies. Although this version of the WB aims to provide a better understanding of the PRM framework, it seems ineffective in presenting striking arguments on the necessity of a medical PRM specialty beyond other medical specialties and non-MD health professions that are usually involved in the medical rehabilitation and prevention process in European countries. Furthermore, concerns are raised related to the presentation of the cost-benefit relationship of PRM and the worldwide naming of the specialty.

The authors chose to describe the specialty right at the gateway between the two World Health Organization twin classifications—the International Classification of Disease (ICD) and the International Classification of Functioning, Disability and Health (ICF) [2]—but incorporated the framework of the ICF as the basis of the PRM specialty. The ICF defines the underlying pathology, the problems at the level of organ functioning, and the potential for restoring/optimizing personal function or preventing further limitation of activity.[1] It considers the ability to participate in the so-

ciety, which depends not only on personal functioning, but also on personal factors (functional ability does not necessarily result in performing respective activities) and contextual factors affecting the individual’s life and environment.

This means that the ICF does not consider disability as a “medical” or “biological/ physiologic” dysfunction only, but rather takes into account the impact of the environment and personal aspects of the respective individual on the person’s functioning. The ICF, thus, “mainstreams” the experience of disability and recognizes it as a universal human experience, which shifts the focus from cause to impact and thereby places different health conditions on an equal footing.[3] The use of the ICF for the comprehensive assessment of a person’s disablement would allow both a “diagnosis” and an estimate of the severity of a person’s impaired functioning and health independent of or beyond the ICD classification. The two World Health Organization classifications, ICD and ICF, therefore may be considered as correlates of two different perspectives in medical care, which would complement each other. The ICD-based perspective in medical care would be disease oriented, whereas the ICF-based one would be functioning oriented.

Describing the PRM specialty right at the gateway between these two complementary World Health Organization classifications may be problematic, because it does not clearly identify the major focus of PRM in medical care. In Europe, such an approach would rather create a major source of conflict with our “neighboring” medical specialties, like neurology, internal me-

dicine, pneumonology, orthopedics, and trauma surgery, as their scope of medical practice would be considered redundant to that of PRM. In most European countries, these medical specialties have in addition to the disease-oriented care traditionally included “organ-specific” functioning-oriented care, like orthopedic rehabilitation, neurorehabilitation, pulmonary rehabilitation, and cardiac rehabilitation. In most European countries, neurologists, trauma surgeons, rheumatologists, and other medical specialists are still responsible for rehabilitation without having undergone comprehensive training in functioning-oriented medical care.

In central Europe, we are facing a steadily growing number of disabled persons who suffer from multiple diseases. As most of the rehabilitation departments/hospitals are specialized in organ-specific rehabilitation, it may become difficult to decide which department/hospital would satisfy best a patient’s needs to optimize his/her functioning and health. Imagine a 53-yr-old patient with a major disablement 4 wks after cardiac bypass surgery who has suffered from a major stroke during the operation and has developed critical illness neuropathy. Other ICD-related problems relevant to this patient are a state after hip-replacement operation 5 wks before bypass surgery, diabetes mellitus, peripheral arterial vessels disease, and chronic back pain. To which “organ specifically” specialized rehabilitation facility would the patient be best admitted to? Is it the neuro, the orthopedic, or the cardiac rehabilitation hospital? And which medical specialist would be best in charge of (and therefore ultimately liable for) the rehabilitation process of this complex patient? Is it the neurologist, the orthopedic surgeon, or the cardiologist who all in addition to their specialty-specific patient-oriented care would also practice organ-specific rehabilitation? Such examples likely illustrate the limits of the existing rehabilitation system in central Europe and are evidence of an increasing demand for a medical specialty, like PRM, that would care for patients with a particular focus on the improvement of impaired functioning and health (as defined by the ICF). We further strongly recommend that all those medical doctors who are specialized in a medical specialty other than PRM and who decide to work in the field of rehabilitation medicine should be trained in PRM, as the step from practicing disease-oriented care to rehabilitative care is usually a major and difficult one. Imagine a trauma/orthopedic surgeon who has managed patients after accidents for many years and who decides to start working as a rehabilitation doctor without having undergone residency. He might feel uneasy because his original professional skills and decision-

making pathways may be of minor relevance in the rehabilitation management of the patient. All, his current concepts of daily practice, rehearsed engrams, and his self-conception of a trauma/orthopedic specialist would clearly differ from or even collide with those of a medical rehabilitation specialist. It would help him, however, to succeed, if he underwent residency in a medical rehabilitation specialty, like PRM, where he would be trained in practicing medicine with a primary focus on functioning-oriented medical care as defined by the ICF.

Accepting the ICF as the basis for the regulations and the requirements for medical rehabilitation, a Physical Medicine and Rehabilitation (PMR) medical specialist would primarily focus on the diagnosis of a patient’s impaired functional health and its respective management process. Accordingly, the PRM specialist would be the medical expert who (1) identified the core problems of a patient based on the ICF, (2) decided whether an interventional program was necessary to improve or maintain a patient’s functioning and health, and, if necessary, (3) prescribed and coordinated targeted treatments and interventions, which might involve services of any specialized rehabilitation/health professional with the aim to best improve or maintain a person’s functioning and health[4]. Thus, the PRM core competencies would be related to providing an estimate of a patient’s rehabilitation prognosis. This process includes (1) knowledge about the pathology underlying a disablement and its respective adaptations, (2) the potential for improvements, and (3) the estimate of a disabled person’s suitability for rehabilitation or tertiary prevention program. Certain diseases may limit a patient’s ability for rehabilitation, or a patient may become medically instable during rehabilitation. Thus, the PRM specialist needs a strong command in both medicine (ICD-based medical care) and knowledge about therapies and treatments offered by rehabilitation and prevention professionals in addition to the medical therapy options, including physical modalities. Finally, the PRM specialist has to balance the risks vs. advantages when selecting and coordinating individual treatments and interventions that are included in the concept of a rehabilitation program.

We recommend defining the primary focus of the PRM medical specialty as promoting and maintaining a person’s functioning and health. This would avoid conflicts and facilitate the understanding for the importance of this specialty when communicated to (1) partners, such as medical doctors of other disciplines or other healthcare professionals, (2) policy makers in

health care concerned with rehabilitation and disability, and (3) the patients themselves, including the representatives of their organizations.

The WB claims comprehensive rehabilitation to be more effective but not necessarily more expensive when compared with standard approach. The authors, however, do not provide references to support this statement. Such a statement might easily be misinterpreted as promoting rehabilitation as a less costly treatment option. In fact, the direct costs for rehabilitation and prevention may be high because of the inclusion of highly specialized health professionals who treat a patient. As we are not aware of high quality research that has clearly demonstrated the cost effectiveness of comprehensive rehabilitation as compared with conventional approaches, such argumentation should be omitted. In our opinion, the World Health Organization provides the strongest argument for a medical rehabilitation specialty by defining rehabilitation as a human right. It would, therefore, be unethical and inhumane to accept less than optimal function and health by restricting to a cost-focused perspective only. Some indirect evidence has emerged that rehabilitation and prevention may eventually pay off, especially when considering the ever-growing population of the elderly. People who arrive at the age of 70 relatively well without limitations in activity, do not only live longer, but create lower healthcare costs as well[5]. Also people who reached the age of 70 in good functional health obviously spend fewer years substantially disabled than people who have activity limitations at the age of 70.

The WB has been written for the medical specialty PRM. We are aware of the fact that all the international society and the European scientific and professional societies have already adopted the name PRM. To our knowledge, however, there are only few countries, if any, where the specialty is officially named PRM yet. To promote the specialty worldwide, it will be of utmost importance to have one authoritative name for the specialty, be it either PRM or PMR, or Rehabilitation Medicine (RM). This and a short characteristic of the specialty, like "PRM/PMR/RM is the medical specialty with special emphasis on optimization of a patient's functioning and health" would certainly contribute to the further promotion of this specialty.

Overall, the revised version of the WB of PRM is a major step forward toward establishing PRM as a specialty with unique features. A revised version of the WB would benefit from presenting the core compe-

tency of the PRM specialist with particular focus on functioning (the ICF-based medical care) and a strong command in disease-oriented medical care (ICD-based medical care). Thus, their role as gate keepers for rehabilitation and health managers might become more obvious. This would also ease promoting PRM relative to all other medical specialties. Based on this modified professional image of a PRM specialist, rules need to be developed that define the interaction and communication between PRM specialists and all the other highly qualified health professionals who collaborate within the health promotion process of a person and with colleagues from our neighboring medical specialties[6]. A recently suggested revision of the definition of the PRM specialty by Stucki and Melvin [7] seems already to comply with such recommendation. The future acceptance of our medical specialty would be further facilitated, if only one individual name would be used worldwide.

References

1. Gutenbrunner C, Ward AB, Chamberlain MA (eds): White book on Physical and Rehabilitation Medicine in Europe. *J Rehabil Med* 2007;39:1–48
2. World Health Organization: The International Classification of Functioning Disability and Health—ICF. Geneva, WHO, ISBN 2001;91 4 154542 9
3. WHO web page: Available at: <http://www.who.int/classifications/icf/en/>
4. Müller K, Ammer K, Berliner M, et al: Ergebnisse der Konsensuskonferenz Physikalische Medizin und Rehabilitation: Rehabilitationsprozess und Rehabilitationsteam (results from the consensus conference on Physical Medicine and Rehabilitation: Rehabilitation process and rehabilitation team). *Österreichische Zeitschrift für Physikalische Medizin und Rehabilitation* 2001;11:11–16
5. Lubitz J, Cai L, Kramarow E, et al: Health, life expectancy, and health care spending among elderly. *N Engl J Med* 2003;349:1048–55
6. Negrini S, Ceravolo G: The White Book on Physical and Rehabilitation Medicine in Europe: A contribution to the growth of our specialty with no boundaries. *Am J Phys Med Rehabil* 2008;87:601–6
7. Stucki G, Melvin J; in cooperation with the Professional Practice Committee of the UEMS PR&M-Section. *J Rehabil Med* 2007;39:38. *Zeitschrift Physikalische Medizin, Rehabilitation, Kurortmedizin* 2006;16:31

Korrespondenzadresse

Prof Dr. Gerold Ebenbichler,

Klinik für Physikalische Medizin und Rehabilitation,
Medizinische Universität Wien,
Währinger Gürtel 18-20,
1090 Wien, Österreich.