

Indian Journal of Physical Medicine & Rehabilitation

April 2001; Volume 12

Editor's Note

TRUTH SHALL PREVAIL

The Speciality of Physical Medicine and Rehabilitation came into existence about 60 years back and has spread and evolved differently in different countries according to need. In some of the western and developed countries it has developed mainly for life long care of disabled persons but the emphasis everywhere is still on making patient useful and active component of the society. Compared to other medical specialities, the development of physical medicine and rehabilitation has not been as radical as it could have been. The trends in other medical specialities have been in the direction of knowledge and skills while we are still sitting as managers and team leaders. It is a known fact that modern world will respect persons with knowledge and skill, not mere managers. We must strive for it.

We have cut our umbilical cord too prematurely. Orthopaedics is the mother speciality from which PMR has evolved and we should continue to develop our skills in the overall management of disabled. There is every reason for us to enter the operative and plaster work in correction of deformities like the ones encountered in polio, cerebral palsy, leprosy, spinal cord injuries (including tuberculosis of spine), peripheral nerve injuries, rheumatoid affections, congenital anomalies, amputations etc. etc. Patients stand to gain from it, and so do we. Local injections, management of pain clinics, phenol and botulinum toxin injections, diagnostic arthroscopy, sports injuries management and training of sports persons, are our natural allies. Orthopaedic surgeons have already started shedding these areas from their routine work and patients do need specialists ready to devote time for this work. A word of caution is essential while undertaking NCV/EMG studies, lest we become "supporting technicians" to the "super specialists". Cardiac Rehabilitation should be done by persons possessing some basic cardiology qualifications, else we get 'blame' and cardiologists get 'name'. Whichever field we tread on, we should be masters of our work.

A thought about nomenclature of the speciality. The word 'physical' has done obvious damage to our identity. Why not shed it? Many specialities have strived for getting their identity by renaming like 'Transfusion Medicine', 'Laboratory Medicine', 'Critical Care Medicine' and so on. We are certainly not experts in rehabilitation of persons affected from supercyclone and earthquake victims or rehabilitation of displaced persons or any other social work. We are practicing medical rehabilitation. Then why not rename our speciality as 'Rehabilitation Medicine'? We need not follow west blindly. We can set trends for them; and certainly they will follow us if our acts are rational. Have we not heard the voices of frustration from foreign faculties visiting our international conferences? The problem is about who will cross the threshold first. Let us!

The standard of teaching and training has remained abysmal in our speciality on the pretext of being new and evolving speciality. Candidates appearing for examinations and interviews clearly reflect the truth. Substandard candidates are awarded qualifications on the ground that ours is a new speciality and we need to build up manpower base. Let us remember that these candidates will form base of the speciality in future and quality of the eventual superstructure cannot be any better.

Bitter truths are difficult to swallow. But we have to face them sometime. Let us face it now, think over it and act in the best interest of the speciality, leaving our marks for the posterity.

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