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Commentary Open Access

Physical Medicine and Rehabilitation: The Case for Physiatrists

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Commentary

Physiatrists are either allopathic (MDs) or osteopathic (DOs) physicians (M.D., D.O.) who have completed four years of residency training to be board-eligible in physical medicine and rehabilitation (PMR). Specialists in PMR treat and manage patients with catastrophic and non-catastrophic injuries and conditions. Their responsibilities include the provision of follow-up medical care as well as ongoing medical and rehabilitation managements.

Physiatrists generally treat patients suffering from traumatic brain or spinal cord injury, stroke, amputation, burns, progressive neurologic diseases, musculoskeletal conditions and disabilities, as well as chronic pain. Thus, physiatrists must have clinical knowledge, training and experience to manage all such patients on a long-term basis which will include the medical complications associated with these conditions. The responsibilities of physiatrists include the definition of a patient's impairment, which is a number assigned to a loss of a body system; disability, which is how the impairment will affect that person's ability to reintegrate back into society; cost for future medical care, and life expectancy. All of these components are defined in a Comprehensive Rehabilitation Evaluation.

In this Commentary, we make the case that physiatrists are the most qualified physicians to render accurate and competent opinions contained in a CRE. This issue is of paramount importance in physical medicine and rehabilitation as the CRE is one of the most powerful tools in the armamentarium of healthcare providers to guide the recovery of patients with impairments and disabilities.

A CRE is a forensic medical report that uses knowledge, training, clinical practice experience, as well as peer reviewed literature to define impairment, disability, cost for future medical care, and life expectancy. A CRE should serve as a guide to the patient's recovery and gives them, their medical providers, insurance companies and parties to any potential litigation surrounding the patients injuries a clear and concise roadmap to the patient's medical history, condition, disability and need for future care and treatment. This report may also be utilized by non-physician decision makers, making its accuracy reliability of paramount importance. A CRE may be challenged by an adverse party, either in litigation or in the insurance context. As a result, it is imperative that the report be accurate, credible and defensible. The best way to ensure that the CRE meets these criteria is for all components of the report, including financial data, to be collected and authored by a qualified physical medicine and rehabilitation physician who should lend his or her credentials to the support and defense of the final product.

Impairment is defined as a significant deviation, loss or loss of use of any body structure or body function in an individual with a health condition, disorder or disease. Disability is defined as activity, limitations and/or participation restrictions in an individual with a health condition, disorder or disease [1].

Defining impairment requires the physiatrist to have a working knowledge of the appropriate guides to the evaluation of impairment. A permanent injury is the most critical factor in the prosecution of a personal injury lawsuit. The requirement of a defined impairment is needed in the federal, civil and worker's compensation arenas. The physiatrist needs to have an acceptable working knowledge in the use of the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment, Sixth Edition. The latest edition of the AMA Guides should always be utilized and physiatrists will have to be familiar enough to have an acceptable working knowledge of that text.

Disability is an impairment that may be cognitive, developmental, intellectual, mental, physical, sensory, or some combination of these. It substantially affects a person's life activities and may be present from birth or occurring during a person's lifetime. Disability is an umbrella term covering impairments, activity limitations, and participation restrictions. Disability is a complex phenomenon reflecting the interactive between the features of a person's body and features of the society in which he or she lives [2].

With extensive experience in clinical practice that involves caregiving to the aforementioned patient populations, a physical medicine and rehabilitation physician (M.D., D.O.) is able to define safe parameters for a patient to return to the work force if able to be accomplished safely. In a CRE, however, objective medical testing is utilized to formalize work restrictions and safe parameters based on objective functional testing so the patient can return to work. Physical functional testing equipment and protocols, such as the BTE and the Biodex, have a totality of peer reviewed evidence to support their normative data. In the medical and legal context, utilizing peer reviewed published normative data and validity testing will withstand legal challenges such as allegations of junk science. With functional testing utilizing normative data and validity testing, these patient's disabilities can be accurately defined using objective measures which can further substantiate the physiatrist's opinions.

The discipline of life care planning was born of necessity before the mid-1970s when a need arose to formulate and/or quantify future care. Physicians or other rehabilitation professionals were often solicited to address three basic questions: 1) What is the subject's condition? 2) What does the subject's condition require? 3) How much will the requirements cost over time? As one might imagine, there was significant variation in the quality, transparency, and legitimacy of

these assessments. At that time the industry was in material need of generally accepted standards [3]. Physiatry has played a central role in a life care plan (LCP), yet less than 1% of life care planners are qualified physicians [3-5]. Non-physician life care planners, as with all experts, are bound by limits of their professional licenses and in the case of non-physician life care planners, this limits their capabilities to perform medical examinations and to independently formulate diagnostic conclusions and opinions regarding impairment, disability, and recommendations for future care [3]. For these reasons, physiatrists have been heavily relied upon by non-physician life care planners. Section 1 of chapter 2 of the Life Care Planning and Case Management Handbook, A Central Text of Life Care Planning, is entitled, "The Role of the Physiatrist in Life Care Planning." It states: "For a life care plan to appropriately provide for all the needs of an individual, the plan must have a strong medical foundation." As physicians specializing in physical medicine and rehabilitation, physiatrists are uniquely qualified to provide a strong medical foundation for life care planning based on their training and experience in providing medical rehabilitation services to patients with disabilities. Physiatrists are uniquely qualified for this task by virtue of their training, experience, and expertise in dealing with patients who have catastrophic functional problems. Additionally, physiatrists are trained to anticipate the long-term needs of their patients [3,4].

A Continuation of Care Plan (CCP) which is a component of a CRE is constructed by a physiatrist (M.D., D.O.) and follows similar methodology that has been described as a LCP [3]. However, a CCP includes contacting as many treating physicians and vendors as possible to confirm procedures, protocols and pricing in the geographic location in which the patient resides or is going to reside.

The spirit and the intent of a CCP is to improve the quality of life of the patient by decreasing morbidity. These strategies include decreasing pain and suffering of patients during the aging process which combined with their impairment leads to a much greater disability over time. We believe that as a person ages they don't feel their pain less but they become more intolerant to pain.

Physiatrists are taught in residency training a comprehensive approach to the assessment of medical and rehabilitation needs and have received the best training to determine what medical conditions remain relevant to the patient's future care considerations [3]. Treating physicians can be of tremendous benefit to a qualified life can planner constructing a CRE, as their experience with the patient may lend valuable insights when crafting a plan unique to that individual [4].

The completion of a CRE should include the consideration of life expectancy. Life expectancy is not a guess as to when a particular person will perish. Life expectancy is a specific statistical concept [6]. The basis for estimating life expectancy is consultation of the literature regarding life expectancy for a particular diagnostic group. The published literature includes multiple peer reviewed articles regarding life expectancy for cerebral palsy, spinal cord injury, traumatic brain injury, coma, persistent vegetative state, and patients with specific cognitive and physical deficits [6].

Physicians who do not thoroughly review relevant medical and scientific data about life expectancy for the particular diagnosis in question should not offer an opinion [7]. To do otherwise, is merely speculation and does not meet the necessary standard for expert testimony within a court of law [8].

Life expectancy is defined as the average number of years of life remaining for persons who have attained a given age [9]. Defining life expectancy requires having a comprehensive understanding of the literature which defines life expectancy within the patient population that is being defined. Life expectancy is different for different conditions such as coma, persistent vegetative state, minimally conscious state, cerebral palsy, and/or hypoxic/anoxic brain injury. When a patient is unable to ambulate and is fed by a G-tube, a spinal cord injury patient who may be a quadriplegic, paraplegic, incomplete or complete lesion, life expectancy should be defined by the strengths of peer reviewed literature regarding the specific patient populations. Without a thorough understanding of peer reviewed published accepted literature within the specific patient population, life expectancy cannot be accurately defined.

In order to produce a CRE, a physiatrist must accurately define the patient's impairment, disability, cost for future medical care, and life expectancy using a medical model. A medical model includes: observation and or performance of a physical exam on the patient, knowledge, training, clinical practice experience, combined with peer reviewed published literature.

When a CRE is produced using the appropriate methodology by the treating or disability evaluation physiatrist, it should then be presented to a medical economist who is familiar with medical inflation rates and discount rates who has the skills to translate those future medical care needs to present money value dollars to determine the ultimate cost needed by the patient. The physiatrist should have extensive working knowledge, clinical practice experience, knowledge of peer reviewed published literature, and utilize accepted methodology to accurately complete a CRE. Failure to follow this prescribed methodology can lead to misleading testimony resulting in disqualification.

An accurate CRE and COC section completed by a qualified physiatrist is paramount in decreasing the patient's pain and suffering thereby increasing their function which will help transform the patient's disability to ability, illness to health and hopelessness to hope.

Disclosures

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Professor Hennekens reported that he serves as an independent scientist in an advisory role to investigators and sponsors as Chair or Member of Data and Safety Monitoring Boards for Amgen, British Heart Foundation, Cadila, Canadian Institutes of Health Research, DalCor, Regeneron, and the Wellcome Foundation, as well as to the United States (U.S.) Food and Drug Administration, and UpToDate; and receives royalties for authorship or editorship of 3 textbooks and as co-inventor on patents for inflammatory markers and cardiovascular disease that are held by Brigham and Women's Hospital; and has an investment management relationship with the West-Bacon Group within

SunTrust Investment Services, which has discretionary investment authority and does not own any common or preferred stock in any pharmaceutical or medical device company.

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