

REHABILITATION MEDICINE AND EARTHQUAKE VICTIMS

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The rehabilitation medicine is a specialty in its early developmental stages, even in the developed world. I am not a statistician or an epidemiologist but as a rehab physician I know that for a country like Britain with the population of around 60 million, there are more than 600 rehabilitation physicians including the trainees. One has to consider the fact that these figures exclude the number of paediatricians and geriatricians who take up a major role in some aspects of rehabilitation management of their respective patients. For a country with the population of 150 million, it would require 1500 such rehab doctors, only to be at par with Britain. The comparison is valid only if one considers, in epidemiological terms, the routine or 'peacetime' disabled population. Add to it the enormous number of victims of the recent earthquake; all the critical evaluations and the statistics go out of the window. The devastation brought about by the earthquake has been very obviously overwhelming for Pakistan.

Making a comparison of the health services in Pakistan with any developed country is not a straightforward matter. This is because the other variables, such as the occurrence of trauma and its type, the extent of mismanagement of the primary injuries, the incidence of secondary infections etc. also come into play. It is sickeningly painful to say that in the ordinary circumstances, many victims of spinal injuries, head injuries, and those with other complications of trauma, never

survive to challenge the rehabilitation potential of the national health services of Pakistan. In addition a good number are 'taken care of' by the faith healers. The Professor of Neurology in Pakistan Institute of Medical Sciences told me that one of such faith healers has specialised in managing stroke patients and he practises near Islamabad. This is obviously due to the lack of appropriate rehab facilities for the community. Pakistan may well be comparable with the rest of the world with respect to the acute medical and surgical management but it lags far behind in the provision of the rehab facilities.

The major aims and objectives of rehabilitation management are to improve the quality of life of the disabled persons. Almost all the patients affected by the disabling conditions, may need help and support for life. In the developed world, there is not much difference in the life span of most of the people suffering from the acquired disabilities. This is largely due to a system of continued support/management program for such a category of patients.

In the UK, the rehabilitation medicine is practised under a number of recognised disciplines that have their own constitution of multidisciplinary teams and set up. They include mainly the Spinal Injuries Management, Neuro-Rehabilitation, the Amputee Management, Orthotics and Orthopaedic Rehabilitation Management. A parallel system exists in the community to follow on from the in-door rehab. The rehab physicians are required to oversee the rehabilitation process, in most cases. It may be noted that the physiotherapy is the most important aspect of rehabilitation management as the occupational therapy, the speech and language therapy, the psychology, the medical and nursing care, and the social worker's efforts.

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THE WORKING OF A MULTIDISCIPLINARY TEAM

The modern concept of managing the disabled is a multidisciplinary team (MDT) work. This means that the individuals work on a patient in their own professional capacity but in consultation with the other members of the multidisciplinary team. The physiotherapist for example, is to be aware of the latest medical status of the patient. They should understand the purpose of all the gadgets and the tubes running in and out of the patient. The nurses need to know the level of transferring skills a particular patient is practising with the physiotherapists. The social workers need to know in advance when patient is likely to be discharged from the ward and in what medical and functional status, as they are to sort out the housing, social and family issues. A doctor depends on speech therapist's assessment of the swallowing capacity of the patient before prescribing medications in a stroke patient. The interdependency is the essence of an MDT working. None of the members of the MDT would take dictation from the other doctor. The role of the rehab physician is that of an overseer. More importantly the patient is part of the MDT.

When it comes to rehabilitation, each group of victims of trauma demand a specific set up and a specific team of professionals to deal with them. The general principle however, is the functional assessment and 'patient-centred', goal-orientated multidisciplinary approach. They all require medical, physical and socio-psychological support. The rehabilitation management of the amputees would involve rehab physician, physiotherapist, occupational therapist, clinical psychologist, social worker and the prosthetist. While a Tissue Viability Nurse has the pivotal role in the management of the spinal injury patients, a speech therapist is vital when it comes to managing the communication problems of the patients with the acquired brain injury.

Managing the soft tissue and other bony injuries is by no means a simple job. This is more complex as each patient is unique in the presentation

of his or her problems. It might require prosthetic support or referring back to the surgeons at times. The management of the somatic, neurological and psychological aspect of pain is one of the most common features in all the above-mentioned groups.

THE MDT MEMBERS

An MDT team may comprise of all of the following:

1. The patient
2. Nurses
3. Support workers
4. Physiotherapists
5. Occupational therapists
6. Clinical Psychologist
7. Speech Therapist
8. Art and leisure therapist
9. Social workers
10. Orthotists
11. Prosthetists
12. Rehab physician

There is no escape from an MDT approach when dealing with the disabled.

THE SUPPORT IS REQUIRED FROM OTHER MEDICAL DISCIPLINES

Despite having a very effective MDT setup, rehabilitation is far from being an autonomous specialty. It requires the help of the colleagues from medical as well as surgical specialties such as orthopaedic surgeons, urologists, general surgeons, plastic surgeons, dentist, psychiatrist, neurosurgeon, neurologist and ophthalmologist. It is essential that surgeons or physicians be approached for help who have the experience of dealing with the disabled people.

THE EARTHQUAKE VICTIMS (TRAUMA PATIENTS)

One would appreciate that the paraplegics are

not the only disabled that require special care.

- i. Spinal Injuries without neurological deficit
 1. Spine is stable
 2. Spine is unstable
 - a. Requiring surgery
 - b. Requiring Orthoses
- ii. Spinal Cord Injuries
 1. Quadriplegics
 2. Paraplegics[both could be incomplete or complete]
- iii. Head injuries
 1. Mild head injuries
 2. Moderate head injuries
 3. Severe head injuries
- iv. Amputees
 1. Upper limb amputees
 2. Lower limb amputees
- v. Bone injuries
 1. Malunited fractures
 2. Non-united fractures
 3. Osteomyelitis
 4. Painful fractures
 5. Unstable and painful joints
- vi. Soft tissue injuries
 1. Soft tissue infections
 2. Tendon/ligament injuries
 3. Soft tissue contractures
 4. Painful soft tissues

NON-EARTHQUAKE TRAUMA VICTIMS

Trauma is a disaster that happens around the clock. It is a part of our daily living. All the above-mentioned categories of injuries exist at a very wide scale in any society. In addition, a number of illnesses such as Stroke, Multiple Sclerosis, and other conditions leading to neurological and physical im-

pairments, prevail in Pakistan. The survivors of the past severe injuries or infections, also need to be looked after. The current status of the management of the disabled in Pakistan is extremely important issue but requires a separate study and research

MY RECENT VISIT TO PAKISTAN

I am a doctor now settled in Britain and have been working in the field of Rehabilitation Medicine for the last nine years. I have been involved in the management of the patients with the Spinal Injuries, Traumatic brain injuries, other acquired brain injuries, amputees, and those disabled requiring posture and orthotic support for seating.

My recent visit to Pakistan was purely a private venture and was initiated by a chain of friends, the other end of which rests at the Federal Institute of Handicap, Islamabad. I also had the chance to visit Pakistan Institute of Medical Sciences, the Armed Forces Institute of Rehabilitation Medicine and the teaching hospital affiliated with Ayub Medical College, Abotabad. I had the great pleasure to speak to the professionals, giving them some flavour of how rehabilitation medicine is practised in the UK. I found people of all grades and levels very welcoming who gave me enormous respect, listening to what I had to say. I had some hint of the devastation that followed the 'event' when the injured got rushed into the hospitals but can never have full appreciation of the chaos brought about by the earthquake as it happened. Whatever my fellow professionals did at that time must have been in good faith and with the intention of caring for the injured as I could sense the same spirit even now when it was time to plan for the rehabilitation of the disabled.

I gathered that the poor physiotherapists are being asked to take the responsibility of a job that requires a team of specialised professionals. This is not at all fair on the physiotherapists who for some reasons would not admit to the authorities but could not hide their frustration on the lack of any medical support, when I spoke to them.

Rehabilitation is NOT the other name of physiotherapy while physiotherapy is not the other name of rehabilitation management.

It tastes bad when we talk of bad things, but to move forwards we must understand where we stand now. From my experience of working in Pakistan from 1983 to 1993, I know that unfortunately, the severely disabled got quickly removed from the hospital wards with the order of a 'dutiful' registrar, telling them to spend their last few months of miserable lives with their loved ones. The quadriplegics especially were pushed around and made to shuttle between the orthopaedic surgeons and the neurosurgeons. No one was ready to allow one of 'his' or 'her' ward bed occupied for months. This meant that the home-grown specialists in these disciplines or specialties were never exposed to such patients and therefore lacked the skill to handle them. Those returning from abroad with higher qualifications and training are also likely to be ignorant of the principles of management of such disabled people. This is because managing disabled requires special professional skills and expertise that the acute side of medicine and surgery lack anywhere in the world. To be honest and truthful, even the sight of a disabled does not seem 'pleasant' to those who are not used to watching and dealing with the people with drooling saliva and unsightly deformities. This is not the case with those professionals who are routinely helping them. Another problem with the 'acute side' is the mindset of curing the disease. While the surgeons and the physicians require such mindset to carry out their professional duties, they tend to run away when it comes to dealing with the incurable disabilities and we cannot blame them. The rehab side tends to make the most out of the potentials that a disabled has, not promising to eradicate the disability. The rehab management is not a "standard" treatment rather it is tailored according to the patient's needs and wishes. Moreover, it cannot be overstressed that managing rehab is a multidisciplinary teamwork and the doctors from the 'acute side' have no concept of

working in a multidisciplinary environment. Surgeons or physicians, they tend to lead from the front, which is a requirement of their job. Therefore, dealing with the disabled is a specialised job even if one is working as a health care assistant.

It is understandable that a sudden demand on the medical professionals for the management of over 600 paraplegics is overwhelming. However, my recent personal experience gives a very grim picture, even otherwise. A team of surgeons and physicians of national fame, in a well-known private hospital in Pakistan, were required to manage my sister-in-law who became paralysed in an incident a few months ago. Despite the honest efforts of the specialists personally known and very dear to me, they were unable to manage the problems of constipation she suffered as a result of her spinal injury and we had to move her to the UK. I can very well imagine the plight of those now being cared for in different hospitals by the staff that never faced such a mammoth challenge in their past experience.

The people of Pakistan, during the last sixty years of their existence have never complained of the inadequacy of the health system with regards to dealing with their disabled relatives. It may well be that even this time they remain "satisfied" with their love ones being looked after by a dedicated team of volunteers, even if placed in Melody Cinema in Islamabad. The ignorance of the public and the medical staff should not be taken as a "blessing in disguise" by anyone. The eyes of the world are watching Pakistanis and it may not be possible this time to 'brush aside' such a *big mess* created by the earthquake. I apologise to the sufferers of the earthquake for my choice of words. Now when the Pakistanis are left with no choice but to learn to manage their disabled, it is the time to learn to do it professionally. I believe the true poverty means being in the state of deprivation of the intellect and the lack of intent in utilising the expertise at hand rather than the shortage of the resources that we keep referring to, time and again. I believe Pakistanis are intellectually a very rich

and resourceful nation. On my recent visit to Pakistan and having spoken to people involved in the rehabilitation management of the earthquake victims, I can proudly say that the intent to know, how to become professionally more helpful to the disabled, was high on everybody's itinerary. Everybody I met was honest in admitting their deficiencies and lack of skills required to deal with the spinal cord injured. Surprisingly and worryingly they were less bothered about the amputees, the head injured, and those with other soft tissue and bony injuries. I was pleased to see the earthquake victims who lost their limbs, getting the artificial limbs fixed by the prosthetics. However, the prosthetists, local or foreign, are only the technicians who make the artificial limbs.

The rehabilitation management of the amputees is much more a task than just fitting an artificial limb.

OUTLINE OF THE SUGGESTIONS

1. A core curriculum for a basic qualification, such as certificate course, needs to be prepared for training in rehabilitation at the federal or provincial levels.
2. The doctors, therapists, psychologists, nurses and the paramedical staff involved in the process of rehabilitation should be encouraged to attend the course.
3. These professionals be given the basic definitions and taught skills according to an approved framework.
4. The central facility should train the instructors who could spread around in the country and train local team members. The process should be standardised in the centre with the potential of modification at the peripheral level.
5. Communication is not an issue these days. The new or modified guidelines may be passed on to the instructors even at the later dates.
6. A blue print should be prepared, if it already does not exist, to incorporate a comprehensive programme to deal with all the victims of disabling conditions as mentioned above.
7. The NGO's should be invited to follow a system that is centrally formulated.
8. Even the faith healers may be engaged in the rehab course. This might well improve their faith-healing skills.
9. I would like to suggest the building of a central rehabilitation facility affiliated with one of the teaching hospitals or a new purpose built rehab centre or else upgrade the Federal Institute of Handicap for that matter.
10. The AFIRM can have a leading role in setting standards as the people in the civil are looking towards them to prepare the required guidelines. It has a huge complex dedicated for rehabilitation that has enormous potential. However, their ways of rehabilitation are based on well-disciplined and established old traditions rather than following an internationally recognisable rehab care pathway.

CONCLUSION

I understand that the authorities in Pakistan are serious in establishing the rehab centres in the country but they do not have sufficient number of rehab physicians to support a big programme. The doctor's job is not just signing or issuing orders for a wheelchair or an artificial limb. Disabled are not managed merely by making purchases of wheelchairs and issuing these to all. It is the posture management that requires professional skills. A rehab physician is more deeply involved in the day-to-day management of the disabled people. There are some qualified rehab physicians in the army but they could be just enough to support their own services. Moreover you need someone from abroad to bring the spirit of multidisciplinary work for the disabled. Therefore I would suggest that the special and generous incentives be given to the foreign doctors to come

and help Pakistan setup the infrastructure for the rehab services. They should be encouraged to invest and exploit the private sector at the same time. The private sector as far as I understand is as good as a blank page when it comes to the rehabilitation management. At least one year long contract be given to those who intend to help from abroad. The best would be to request the international organisations to pay for the expenditures incurred on bringing the foreign professionals. The best chance would be the foreign nationals of Pakistani origin or people with dual nationality for that mat-

ter, so be approached. It is not of much help if people come for a visit or two but are less likely to settle and help you manage persistent constipation, recurrent urinary problems and the 'stubborn' pressure sores. These are some of the life long as well as life threatening problems that the poor victims are facing.

Let no one say that those who died in the quake had been luckier than the crippled survivors.

