To those who are unfortunately affected by disease or injury, it is the goal of rehabilitation to develop their physical, psychological and social capabilities to the best possible extent within the limits of their disabilities. This should be achieved in the shortest duration. Rehabilitation is an integral part of orthopaedic treatment. For many orthopaedic problems, closure of a surgical wound is by no means the end point of management. Oftentimes, the operative intervention positions the patient along the correct direction in the path towards recovery. It must be complemented with timely and appropriate rehabilitation to achieve the desired outcome. Without proper rehabilitation, the result of an operation, no matter how expertly performed, may end up even worse than without treatment. For example, if a repaired flexor tendon of the finger is not rehabilitated properly, the finger may end up ankylosed in an awkward position. The function of the hand may be even worse than had the tendon not been repaired at all. In the correction of musculoskeletal disorders, the orthopaedic operation is frequently just one step in the entire treatment process. A good rehabilitation program is indispensable for maintaining the correction achieved by the scalpel and sometimes even to further improve on what was surgically attained.

The rehabilitation team is headed by a specialist (known as a physiatrist in North America). In countries of the Asia-Pacific region, the team often consists of a physician or orthopaedic surgeon with higher training in rehabilitation, a physiotherapist and an occupational therapist, rehabilitation nurses, a prosthetist-orthotist, a clinical psychologist, a medical social worker, and any other medical specialists necessary for a particular condition, such as a urologist when bladder care is involved. A patient should receive detailed evaluation by the team prior to commencement of a rehabilitation program. The aims of the program are determined, and the timetable is set. Thus if the patient has sustained a spinal cord injury with resultant paraparesis, then the aim is to return the patient to ambulatory status with appropriate walking aids within a period of say 2 to 4 months (with 2 months being increasingly the target in modern rehabilitation centres).

Whereas statistics are lacking in most member countries of the Asia Pacific Orthopaedic Association, a 1997 report on the rehabilitation medicine workforce in Australia pointed to a shortage of consultants. It said that no state or territory was near the recommended consultants to population bench-mark. Waiting times were comparatively long and there was a shortage of trainees. The situation was unlikely to improve in the short term.

The report recommended establishing a national rehabilitation network to oversee the development of appropriate rehabilitation infrastructures and services. It urged health authorities to show their commitment to investing in rehabilitation.

At least in Australia, there was an estimate of how many consultants were available in rehabilitation medicine. In 1997 there were 169, with a consultant to population ratio of 1 to 108,220. The recommended ratio was however 1 to 50,000. The waiting time for a first consultation was 15 days for private and 22 days for public services. In most other member countries of APOA, the situation may be far worse. Japan is noted to have a sophisticated rehabilitation network, but we were unable to find sufficient data.
A global survey conducted by the American Board of Physical Medicine and Rehabilitation in 1999 found that 43 countries around the world offered residency training in rehabilitation medicine (physical medicine and rehabilitation). Of these, 41 countries gave a certifying examination. There were a total of 25,381 specialists in rehabilitation medicine in practice at the time.

In the Asia-Pacific region, there were 11 countries involved, with a total of 5,084 specialists. The number of years of postgraduate training in the specialty varied from 3 to more than 6. Residents were usually required to train in inpatient general rehabilitation, stroke rehabilitation, spinal cord injury, brain injury, geriatrics, outpatient musculo-skeletal medicine, pain management and paediatric rehabilitation.

While rehabilitation medicine is a well-established specialty in Australia and New Zealand, in most member countries of the APOA, specialization in rehabilitation medicine is severely deficient. The Australasian Faculty of Rehabilitation Medicine, under the Royal Australasian College of Physicians, oversees the training program in adult rehabilitation medicine, whereas paediatric rehabilitation is under the Paediatrics and Child Health Division of the same College. Training under the College takes 6 years, including 3 years of basic and 3 years of higher training. As at April 1997, there were 72 accredited training posts, but only 25 of these (35%) were occupied.

In Hong Kong, the College of Orthopaedic Surgeons recently approved a post-fellowship training program in rehabilitation medicine. Thus in Hong Kong, an orthopaedic rehabilitation specialist will need 7 years of training, namely 2 years of basic surgical training, 3 years of higher orthopaedic training and 2 years of training in musculo-skeletal rehabilitation. This may not be a model of economy and we do not necessarily recommend it for other Asia-Pacific countries or territories.

We conclude that there is a need to establish a much closer dialogue within APOA, perhaps with the formation of a formal group, to study the needs of the region, and to make recommendations on the implementation of training programs, infrastructures and services, so that our member countries may look forward to meeting their people’s rehabilitation needs in the foreseeable future.

REFERENCES
