



# Review on Graduate Medical Education and Sub Specialization amid Changing Demographics Physical Medicine

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## Introduction

In undergraduate medical schools, physical medicine and rehabilitation clerkships are not underrepresented, but they are underemphasized. Additionally, the learning objectives for these clerkships are not consistent. As a result, the findings call for the creation of a list of standardized learning objectives and the promotion of physical medicine and rehabilitation clerkships as selectives. The community of physical medicine and rehabilitation is invited to test this ground-breaking list that was created by this exploratory study. The Archives of Physical Medicine and Rehabilitation started out as a journal for radiology [1]. Over the course of its century-plus existence, it has changed its name and shifted its focus from radiology to physical medicine and rehabilitation to physical medicine and rehabilitation. These changes are outlined considering the development of physical medicine and rehabilitation in the United States, which eventually merged, as well as social history in the United States and elsewhere. Due in part to the varied use of standardized curricula, physical medicine and rehabilitation residency programs do not provide a uniform level of training and mentorship for resident scholarly activities. Using standardized methodology, the purpose of this study was to develop, implement, and evaluate a structured Quality Improvement and Research Curriculum for a physical medicine and rehabilitation residency program in 2015. To integrate existing resources into five institutional domains of the Patient Safety and Quality Improvement Program, a combination of five-phase project lifecycle and six-step medical curriculum development methodologies were used. Program for Mentoring in Research; Review of rehab; Resources for Presentations and Publications, as well as a Research and QI Lecture Series For each domain and the curriculum, specialized resident-faculty teams were established. Tracking tables, reporting forms, and scope documents were all created as written materials. An easily accessible resource was provided by a dedicated page on the department's website. Residents' ongoing accomplishments were highlighted in a bimonthly Updates newsletter. Midway through and at the end of the 2015 academic year, program and resident outcome metrics were evaluated [2]. Brilliant occupant and great personnel cooperation in the educational program was noticed. Occupant distribution and show efficiency gotten to the next level. The greatest obstacle to success was time. Phased implementation, dedicated teams, scope clarity, accessibility to resources, personnel support, resident champions, and faculty mentorship were all crucial to success. The purpose of this study was to provide a description of the provision of acute care consultations in Physical Medicine and Rehabilitation in the United States and Canada [3]. An 18-item questionnaire was sent to department chairs and division directors of Physical Medicine and Rehabilitation departments at academic centres in Canada and the United States. Seven of 13 Canadian surveys, or 54%, and 26 of 78 American surveys, or 33%, were returned. A majority of academic institutions in both the United States and Canada offer consultations for acute care; However, there were some differences between nations. When compared to Canadians, a greater number of American respondents indicated that they use a specialized acute care consultation service model. Professionalism is

the foundation for core competencies in medical education, clinical practice, and research, and it is embraced by everyone in the medical profession. For responsible patient care, physical medicine and rehabilitation physicians must master a vast body of knowledge [4]. Professionals in rehabilitation work in a variety of settings; However, in accordance with the specialty and national standards, each must establish and uphold ethical standards. For instance, professionalism is one of the six core competencies that the Accreditation Council for Graduate Medical Education states that trainees must master. Professionalism and some of the ethical questions it raises are gaining popularity [5]. A general overview of professionalism is provided in this report. There will need to be more reports in the future, and this is a good time to think more deeply about many aspects of professionalism. In obesity, the professional role of PRM physicians is to propose a comprehensive PRM treatment for patients considering comorbidities, impairments, limitations on activity and participation, provide medical care to the multidisciplinary team, and coordinate the individual PRM project developed in collaboration with the patient and his family or caregivers. Physical Medicine and Rehabilitation (PM&R), also known as physiatry, is a medical specialty that focuses on helping people who have been disabled by a disease, disorder, or injury regain their function. By addressing an individual's physical, emotional, medical, vocational, and social requirements, physiatry provides integrated, multidisciplinary care with the goal of total recovery. A physiatrist is a doctor who focuses on physical medicine and rehabilitation. The process of assisting an individual in achieving the highest possible level of function, independence, and quality of life is known as rehabilitation. Rehab aids in the person's return to optimal health, functioning, and well-being rather than undoing the damage caused by disease or injury [6]. To rehabilitate is to become able. Physical medicine and rehabilitation is a branch of medicine that helps people get back the body functions they lost as a result of an injury or medical condition. The entire medical team, not just the doctors, is frequently referred to using this term. Many body functions, such as problems with the bowel and bladder, chewing and swallowing, thinking or reasoning, movement or mobility, and speech and language, can all benefit from rehabilitation. The goal of physical medicine and rehabilitation (PM&R), which is also known as physiatry or rehabilitation medicine, is to improve and restore functional ability as well as quality of life for people who have physical disabilities that affect the brain, spinal cord, nerves, bones, joints,

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ligaments, muscles, and tendons. A physiatrist is a physician who has completed training in this area. The physiatrist's objectives are to increase quality of life and maximize patients' independence in daily activities, in contrast to those of other medical specialties that place an emphasis on a medical cure [7]. Physiatrists are specialists in planning far reaching, patient-focused treatment designs, and are essential individuals from the consideration group. They use bleeding edge as well as reliable medicines to expand capability and personal satisfaction for their patients, who can go in age from new born children to octogenarians [8]. Spinal cord injury, brain injury (both traumatic and non-traumatic), stroke, multiple sclerosis, polio, burn care, and musculoskeletal and paediatric rehabilitation are some of the most common diagnoses and populations seen by inpatient physiatrists. To manage these issues, inpatient physiatrists frequently have collaborative team skills training and collaborate with social workers and other allied health therapists (such as physical, occupational, and speech therapists). Orthopaedic injuries, spine-related pain and dysfunction, occupational injuries and overuse syndromes, neurogenic bowel and bladder, pressure sore management, spasticity management, and chronic pain are all handled by outpatient physiatrists. Multidisciplinary groups of other physiatrists, orthopaedic surgeons, and/or neurosurgeons typically include outpatient physiatrists. A wide range of patient populations and clinical settings are covered by physical medicine and rehabilitation. Amputation, spinal cord injury, stroke, traumatic brain injury, and other debilitating conditions are frequently treated by physiatrists in hospital settings. Physical, occupational, recreational, and speech therapists, nurses, psychologists, and social workers work together with physiatrists to treat these patients. In short term settings, physiatrists treat patients with muscle and joint wounds, torment disorders, non-recuperating wounds, and other debilitating circumstances. As a pain management option, physiatrists are trained to inject into joints or muscles. Additionally, electromyography and nerve conduction studies are taught to physical therapists. The main goal of physical medicine and rehabilitation treatment is to help a person live their best life within the constraints of a disability or disease process that has no known cure. For those who are unable to achieve full restoration, the focus is on improving quality of life rather than complete restoration to pre-morbid function. In order to coordinate patient care, an emphasis is placed on a team approach to chronic conditions. As facilitators, team leaders, and medical experts for rehabilitation, specialists in this field provide comprehensive rehabilitation. The clinical care team often uses goal setting in rehabilitation to give the team and the person undergoing rehabilitation for an acquired disability something to work toward. It is unclear whether goal setting in this setting reduces or increases re-hospitalization or death, and there is very little evidence to suggest that goal setting may improve the person with the disability's quality of life. A physiatrist must not only have medical knowledge of a patient's condition, but they must also have practical knowledge of it. This includes issues like: what kind of wheelchair or prosthetic would be best for the patient, what kind of prosthetic would be best for them, and what other everyday problems their patients might have. The medical treatment of diseases and disorders with a variety of physical energy forms is known as physical medicine. Numerous clinical disciplines utilize actual strategies in their everyday practice. In general, electrocoagulation, lasers, and cryosurgery are utilized by surgeons; Radiofrequency rhizotomy is particularly used by neurosurgeons; The electroconvulsive therapy is used by psychiatrists; Defibrillation is used by cardiologists; also, dermatologists use lasers. For paralyzed muscles, electrostimulation is used in medical rehabilitation, and chiropractors use manual manipulation for spinal issues. Some physical therapies

have even emerged as distinct official medical specialties: for instance, radiation therapy for cancer. Notwithstanding, there is a gathering of purported reflexive treatments, which utilize different types of actual energy to invigorate and control the body's own self-protection instruments and frameworks [9]. These treatments have emerged as their own distinct branch of clinical medicine because of the very specific way in which they operate: physical medicine with a reflex. Reflexology treatments include: thermotherapy (heat or cryostimulation), phototherapy (infrared, ultraviolet, or laser), ultrasound therapy, magnetotherapy, electrotherapy (direct or through electromagnetic energy), and mechanical nerve stimulation The use of various injections, including bee stings, plasters, compresses, and creams, as well as chemical stimulation of the skin's nervous receptors, falls into the same category because the chemicals are used as nervous stimuli rather than as medications [10]. Always keep in mind that, for instance, in electrotherapy, the problem is not solved by the electrode, and in acupuncture, the problem is not solved by the needle; These are merely tools for controlling and stimulating the body's powerful self-defence systems and mechanisms. After all, the human body is the best "pharmaceutical factory" because, under normal circumstances, it can produce any necessary substance.

## Conclusion

Due to significant advancements in contemporary pharmacology, certain traditional indications for reflexive physical medicine, such as ischemic heart disease, hypertension, peptic ulcer disease, diarrhoea, urinary tract infection, impotence, and so on, are no longer valid. Reflexology, on the other hand, should continue to be the first option for a wide variety of ills. For instance, even after several unsuccessful spinal surgeries, these treatments are especially effective for treating severe back pain. When it comes to treating persistent headaches, neuralgias (intercostal, trigeminal, or postherpetic), neuropathies (such as diabetic), phantom pains, reflex sympathetic dystrophy, Reynaud syndrome, chronic rhinitis/sinusitis, Meniere syndrome, tinnitus, hearing loss because of damage to the acoustic nerve, Bell's palsy, glaucoma, they can be noticeably successful as a steady treatment of Parkinsonism. Traditional applications of reflexive physical medicine include sports injuries, various forms of arthritis, acute gout, and ankylosing spondylitis. When it comes to chronic illnesses of the respiratory tract, it can be very helpful. Even in acute conditions, these more radical reflexive therapies, particularly electroacupuncture and cryo stimulation (70-160 degrees Celsius), can be used effectively: for instance, asthmaticus, atonic uterus, renal colic, esophagospasm, severe migraine, or pain after surgery. Additionally, electroacupuncture is by far the most effective method for treating nicotine dependence.

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