British Society of Rehabilitation Medicine

Promoting quality through education and standards

4 August 2021

# Discussion document on the proposal to change the name of the British Society of Rehabilitation Medicine

## Introduction

This document aspires to help the Society come to a view as to the advantages and disadvantages of a change in name from British Society of Rehabilitation Medicine to British Society of Physical & Rehabilitation Medicine. We hope that it will constitute the basis of future discussion both remotely and in person to inform a future formal ballot of members at which a simple majority is binding. If this debate is conducted in the right way, it should be formative in clarifying our future direction both as a Society and as a Specialty. This vote is only about a change in the name of the SOCIETY and not for a change in the name of the specialty. A change in the name of the specialty can only be enacted by the GMC and there is concern from some members, and the chair of the RCP Joint Specialty Committee for Rehabilitation Medicine, that this could be a potential risk to our continued recognition as a separate medical specialty. The document needs to be read in this light even when the introduction, and some other sections, discuss our whole specialty.

The GMC had, until a pivotal document in the 1980s[1], held an unquestioning belief that, unlike almost all other developed nations, the UK could meet the needs of its disabled population without a designated specialty. It was proposed that each specialty should be responsible for meeting the rehabilitation needs of conditions pertinent their own area of specialism. At that time most other countries in Europe had a specialty of Physical Medicine & Rehabilitation but with the term Physiatry established in the USA and Rehabilitation Medicine in Australia.

Physical Medicine had been practiced since the 19th century but developed hugely during the First World War. It referred to physical treatments applied to injured soldiers including physical therapy, electrical therapies, artificial limbs/orthotics and water-based treatments. Although a British Society of Physical Medicine was founded in the 1930s these forms of treatment developed much more on the Continent focused on spas and hydrotherapy/balneotherapy. The Romanian society was, for instance, originally named the Romanian Society of Hydrology. The terms Physical Medicine and Physical Therapy were used somewhat interchangeably in Europe in 1940-1950s so that the founding documents of the EU described our specialty as ‘Physiotherapy’, a title that our European colleagues have been trying strenuously to change.

I understand that the term Rehabilitation was first used in the UK in the 1940s with reference to wounded soldiers. Its use became rapidly established in a health context and was applied to the management of musculoskeletal conditions within a newly formed specialty of Rheumatology & Rehabilitation. Rheumatologists played a

significant role in the formation of our sister organisation, the Society for Research in Rehabilitation, in 1978. It was the view at that time that the term Rehabilitation could only be properly used in the context of an improvable condition and the authors of the pivotal document *Physical Disability 1986 and Beyond*[1] in their recommendation for designated Consultant sessions, proposed the term Disability Medicine. With the expansion of Rheumatology its proponents no longer felt that their work should necessarily be concerned with the management and rehabilitation of non-rheumatic, particularly neurological, disease and The Medical Disability Society was founded in 1984 with a focus on such non-rheumatic conditions. The 1986 document proposed 30-35 new full time senior registrars in Disability (Rehabilitation) Medicine to work in regional centres. The term Rehabilitation Medicine gained currency and within six years the Medical Disability Society was renamed the British Society of Rehabilitation Medicine.

The specialty brought together doctors working in Spinal Injury Units, Artificial Limbs and Appliances Centres, Neurologists and Rheumatologists with a special interest. The curriculum for the specialty in 2007 and 2010 reflected this group of interests. This led to a survey of trainees in 2011 which demonstrated shortfalls in training opportunities in musculoskeletal medicine and in 2016 concern about the slow growth in consultant numbers, coupled with increasing disquiet about the restricted scope of the curriculum, led to the production of the Rehabilitation Medicine Expansion Proposal. In 2020 the new curriculum enlarged the scope of the specialty to cover all rehabilitation as practiced in other countries. At the executive committee in October 2020, it was agreed to hold a ballot on the name of the Society to reflect the terms used elsewhere in Europe where the specialty is much larger and apparently more successful. In both Europe and North America there are about ten times as many consultants per unit population many working in a salaried position in large rehabilitation hospitals or offering fee-for-service work in private offices.

The Executive Committee agreed that the BSRM membership deserve the opportunity to have a democratic debate about the name of their representative society. Many of us have experience of the specialty internationally and I hope that, following discussion based on the information summarised in this document, we will be well placed to determine the future direction of the Society and the specialty. I am confident that this important vote on the name of the Society will be an expression of carefully considered positions.

This document is not the beginning of this discussion within the Society but attempts to bring together the views on both sides of the debate. The authors are Julian Harriss, who has experience of working abroad, and Derick Wade because of his role developing the new curriculum. Sara Ajina and Javad Haider were invited as newly appointed consultants with an eye to the future. I have convened this group with the principle intention to preserve the unity of the Society but do not espouse a particular view or choice.

## Possible Discussion Questions

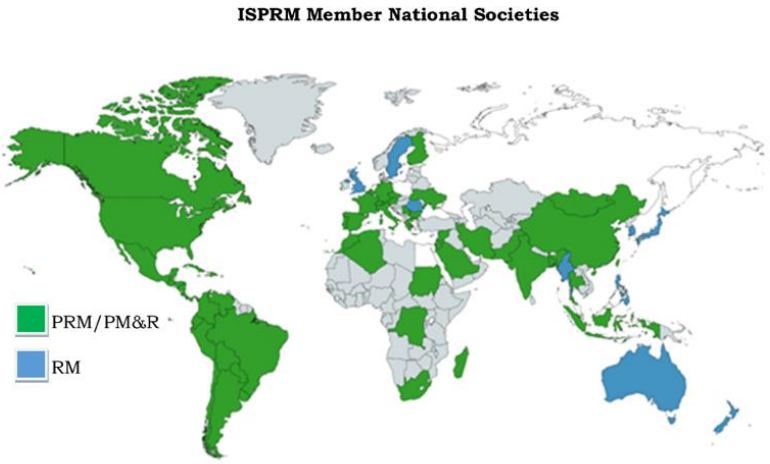
1. Would changing the name of the Society make what we are about clearer to colleagues and patients. Would it improve our ‘brand’ and make us more attractive to our referrers, or might the risk to our reputation and profile outweigh the benefit?
2. Would changing the name of the Society promote a broadening of scope and increase the practice of MSK rehabilitation? Is this relevant to Long COVID?
3. Would changing the name of the Society impair our relationship with the therapy professions and make the Society less attractive to them by inferring that there is a separate area of activity ‘Physical Medicine’. Does it matter? Do we want a Society that is primarily about a medical specialty or one that is primarily about the promotion of rehabilitation as a whole?
4. Would changing the name of the Society improve growth in the number of consultants? Would aligning our name with apparently more successful sister specialties in other countries increase the likelihood of us being successful, or are there more important determinants that a change of name cannot influence? Will it have a positive influence on commissioners/employers?
5. Would changing the name of the Society infer less interest in mental health, cognition and behaviour?
6. Would changing the name of the Society make any difference to how the Society is viewed nationally and internationally?
7. Would changing the name of the Society subject it to a financial cost that it should not currently pursue? I intend to inform members of the estimated cost of changing the domain name, our logo etc. The Society has agreed to meet the cost of the ballot itself.

**Dr John Burn**
**Consultant in Rehabilitation & Brain Injury**

## Arguments in support of the proposal to change the name of the society to the British Society of Physical and Rehabilitation Medicine

Rehabilitation physicians in the UK will need an expanded skill set outside of traditional scopes of practice to better prepare for the multisystem challenges that lay ahead in the post-Covid era. Patients with long covid present with needs requiring cardiopulmonary and musculoskeletal rehabilitation which are established areas of practice internationally under the banner of Physical and Rehabilitation Medicine. The urgency with which we must broaden the scope of our society to encompass these areas means that the choice on society name change comes at a critical time.

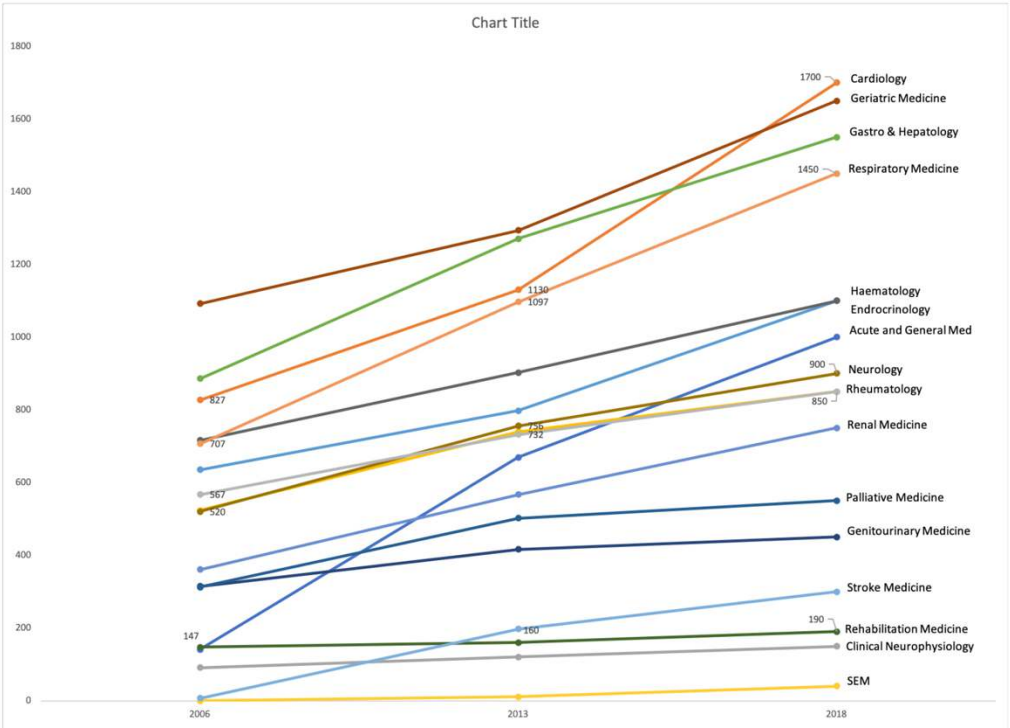
A 2011 survey of RM trainees[2] showed that most responders thought the scope of practice of RM in musculoskeletal medicine in the UK was too limited and preferred the name Physical and Rehabilitation Medicine. By way of contrast, specialists in Physical and Rehabilitation Medicine (PRM) or Physical Medicine and Rehabilitation (PM&R) enjoy a far broader scope to their work, with multiple subspecialties under one broad umbrella (the countries highlighted in green in the map have the word 'physical' in their societies and have far greater workforce than the ones highlighted in blue).




Our 2018 society constitution and our current training curriculum[3], make it clear that we aim to be physicians serving those with *"disability of any cause and affecting any organ system"* and delivering a *"patient-centred service aimed at ameliorating the wider consequences of any illness."* Despite the breadth of this definition, there are still remarkably few RM consultants practicing in the UK – only around 230 for a UK population of 66 million and a society with membership around 350 (including trainees). For a society unconstrained by anatomical or pathological demarcations and given the number of individuals with disabling chronic conditions, the current workforce and society membership is clearly inadequate.

Few RM consultants in the UK work and teach beyond the narrow constraints of Brain Injury Rehabilitation, Spinal Cord Injury Rehabilitation, Amputee Rehabilitation and more recently Major Trauma rehabilitation. By contrast, our colleagues in other countries practicing under the standard of PRM or PM&R are expected to work across a huge variety of fields, taking leadership roles in Musculoskeletal Medicine and Rehabilitation, Pain Medicine, Cardiac Rehabilitation, Pulmonary Rehabilitation, Cancer Rehabilitation and Paediatric Rehabilitation.

While workforce numbers are influenced by a variety of factors, it is our view that the narrow scope of practice of RM in the UK will have contributed to the stagnant growth of our workforce in last 20 years when compared to other medical specialties (the below graph shows on an average the medical specialties workforce doubled between 2006 and 2018 but RM grew only by 30%).




It is certainly the case that there is a reluctance to commission RM sessions in musculoskeletal, pain, cancer, cardiac, pulmonary and other services where clinical rehabilitation expertise is required. This reluctance we feel reflects the historical narrow scope of practice of RM in the UK and has led to a lack of appreciation for the value our society brings to these patient groups. While efforts have been made to widen the scope with the new curriculum, we feel a fresh approach through the renaming of our society to include PRM emphasises our ambition to extend ourselves into clinical services routinely populated by our international PRM/PM&R colleagues.

The term ‘physical’ has been an integral part of the society internationally and in the UK right from its inception. There have been several discussions around the etymological, philosophical and pragmatic implications of inclusion of the term ‘physical’ alongside rehabilitation medicine and we refer the reader to several key papers. [4,5]

Nevertheless, it is clear the inclusion of the term ‘physical’ within other national specialty societies has not hindered the involvement of PRM/PM&R physicians in key clinical services for disability populations. Rather, national specialty societies using the term ‘physical’ have continued to flourish. Hence any concerns around a change of name adversely affecting our society are unfounded.

In summary, by changing our name to British Society of Physical and Rehabilitation Medicine, it is our assertion that we will:

- Increase our society membership by attracting clinicians from Sport and Exercise Medicine (SEM), Pain, Cancer Rehab and Cardiopulmonary Rehab to join us that enables us have a greater impact as a society on disability care and health policy.
- Bring our society in line with the rest of the world and foster growth in our workforce, so that we meet the international standards and deliver the medical workforce needed to manage people with disability. Currently we are at 10% of the required strength: 0.2 consultants/100,000 population whereas we need to be 2/100,000.
- Bring back Musculoskeletal Medicine expertise to the society, which we lost to other societies in spite of musculoskeletal problems and chronic pain being the single largest cause of disability in any population and should be one of our main focus areas of practice.
- Give us a broader, fresher outlook and allow us to work collaboratively with our peers outside the UK on educational, clinical and research projects and bring a sense of international equivalence with rest of the world.
- Encourage PRM trained clinicians from outside the UK to work in clinical posts in the UK which we have constantly failed to fill and reduce our risk of losing posts due to failed recruitment.

By choosing to remain the British Society of Rehabilitation Medicine, it is our assertion that we will:

- Fail to address the ambiguous nature of our scope and expertise and perpetuate the confusion that we are somehow different or inferior to our peers in the rest of the world.
- Continue the fragmented nature of our RM society (RM, SEM, Pain, Cancer Rehab, Cardiopulmonary Rehab are all currently separate societies) and failing to be working under one banner and serving those with disability irrespective of cause and organ system.

**Julian Harriss Consultant in Physical Medicine and Rehabilitation**
**Javvad Haider Consultant in Rehabilitation Medicine**

## To maintain the current name of our Society

A Society is "*an organization or club formed for a particular purpose or activity".* [OED] In our society, the activity that members specialise in is rehabilitation. The society's constitution has five objectives, but the second objective is probably the primary one: *"to promote the* ***specialty of Rehabilitation Medicine****, being defined as the application of medical skill to the diagnosis and management of disabling disease and injury of whatever cause and affecting any system of the body."* Although the Society's major political and practical influence is within the United Kingdom, we are keen to establish links world-wide, to learn from and to influence people in other countries.

The Society's name needs to encompass these facts as succinctly and clearly as it can. The obvious name to do this is the British Society of Rehabilitation Medicine. As a Society, our primary focus is on rehabilitation. Most of our membership are medical doctors, and the medical specialty is Rehabilitation Medicine. Any person who discovered the name of the specialty from university departments (either rehabilitation or rehabilitation medicine) or from the General Medical Council's list of medical specialities would also naturally expect the society to have this name.

Therefore, if this were not already our name, the argument to make it our name would be irresistible. **An even more important reason for choosing the existing name is political.**

The specialty will only grow to meet the undoubted and undisputed need for rehabilitation if the specialty, through the Society, has greater political influence. This influence has two main roots. The first is the number of members, particularly people with a firm life-time commitment to rehabilitation. The second is that the society is seen as representing rehabilitation services.

Three ways to grow are:

- recruiting and retaining all doctors practicing as Rehabilitation Medicine specialists;
- recruiting doctors in other specialities (e.g. geriatrics) doing rehabilitation;
- recruiting Rehabilitation Specialists from other professions.

Only the second and third approaches will achieve the greater political influence needed. It could increase numbers considerably. It would undoubtedly give us much greater credibility as representing rehabilitation.

## Will changing the name affect political influence?

In the proposed new name (physical and rehabilitation medicine), the word, physical, has two possible meanings: physical medicine, or physical rehabilitation. If the former it will suggest that the doctors are no longer specialised in rehabilitation, but that they are specialised in 'Physical Medicine', and most people in the UK will simply not know what it means or why it is there. If the latter, it will lead to a perception that the society's members have less interest in the cognitive and psychological aspects of a patient.

The society has become well-known with its present name, and ***any*** change of name risks losing the invaluable asset of being familiar and understood. Many organisations have suffered after changing a name.

It has been difficult to gain recognition that rehabilitation is important, and requires expertise. It has also been difficult to gain recognition of the hidden cognitive and psychological problems associated with disabling conditions. Introducing a new word into our name risks weakening our influence **and** our ability to recruit new members, both from other medical specialities, and from professions.

In summary, the proposed name, British Society of Rehabilitation Medicine:

- expresses unambiguously and succinctly the nature of the society
- it relates directly to the GMC-recognised specialty of Rehabilitation Medicine
- facilitates recruiting experts in rehabilitation from other professions and other medical specialities, which will increase numbers, increase representativeness, and thus increase political influence
- retains our existing hard-won reputation and increasing influence.

## Why change to British Society of Physical and Rehabilitation Medicine?

The proponents suggest that the new name will:

1. broaden the scope of practice
2. increase the number of consultants in Rehabilitation Medicine (**Note:** the name of the specialty cannot be changed without great difficulty, and delay)
3. bring the name into line with some other rehabilitation societies.

1. The need to broaden the scope of **training** was recognised in about 2011, just after the new 2010 curriculum had been accepted. There was no opportunity to alter the curriculum until 2017. The new 2021 curriculum has a very broad curriculum in line with or exceeding that in other countries. The scope of **practice** is determined by (a) the training consultants have received, (b) the expertise within the existing consultant workforce, and (c) the scope of commissioned rehabilitation services.

   The general rehabilitation skills of the current workforce is sufficient to take on patients after trauma and Covid-19, and will be much greater in four years' time. In

practice, it is commissioning that limits the scope of rehabilitation doctors. Changing the name of the **Society** will not have any influence.

It is agreed by all, including commissioners on an informal basis, that more expert rehabilitation doctors and more rehabilitation services are needed. As suggested above, the **Society** could increase its size by attracting in doctors from other specialities who undertake and are interested in rehabilitation. If anything, the addition of the word 'Physical' would move us away from the principal association between our specialty and other specialities, which is **rehabilitation**.

2. The number of consultants in every specialty is determined politically, through the Department of Health, who have limited all specialities severely, using financial resource, not clinical need to determine numbers (https://committees.parliament.uk/publications/6158/documents/68766/default/). The total number of trainees across all specialities (including general practice) has not changed significantly in 10 years. The number of consultant posts has generally increased, but at a slower rate than the increase in need. The relative numbers in different specialities and the absolute numbers are determined by commissioners. Trusts will not appoint a consultant if commissioners will not pay for the service he or she will work in.

   Changing the name of the **Society** cannot alter the number of consultants or training posts.

3. The third reason given concerns comparability with the names used by other rehabilitation societies around the world, as represent by the International Society of Physical and Rehabilitation Medicine (ISPRM).

   Of the 75 countries in the ISPRM list, only 8 of the national societies are in Physical and Rehabilitation Medicine, 43 are Physical Medicine and Rehabilitation, 16 are Rehabilitation Medicine, with 8 other names. A respectable 21% use Rehabilitation Medicine as their name.

   Moreover, one big rehabilitation society in the US is the American Congress of Rehabilitation Medicine (owners of the Archives of Physical Medicine and Rehabilitation). This society changed its name from the American Congress of Physical Medicine (the name from 1944) to the American Congress of Rehabilitation Medicine in 1966. This was a response to *"the need for a forum in which members of various rehabilitation disciplines could share their professional, scientific, and technical talents."*

   There is no obvious benefit to this Society from having a name similar to the name used by rehabilitation societies elsewhere in the world, and the proponents do not suggest any benefit. There is a **significant risk**, in that most UK patients and

policy makers will not know what the term, Physical means in the context of Rehabilitation Medicine.

‘Physical’; other considerations

The primary meaning of Physical is “relating to the body as opposed to the mind” [OED] and its use probably originated from the historical focus on exercise, use of electricity, and manipulation – still significant areas of clinical practice in some countries but, with the exception of exercise, not in the UK.

It could be argued that the etymology of physical comes from Latin, *physica* (things relating to nature) which, in Middle English became *physic* (medicine) and *physical* (relating to medicine). It is unlikely that many people will naturally consider this meaning, which is anyway tautologous, just reinforcing the ‘Medicine’ already in the name.

When considering the importance of research in our specialty, there is minimal focus on ‘physical medicine’ worldwide. A Medline search for ‘physical medicine’ finds papers concerning the specialty, not clinical research. All research is in Rehabilitation, with over 180,000 articles published 2010-2020, compared to 35,000 in Physical Medicine.

Last, a search for definitions of rehabilitation undertaken by researchers from Italy, Turkey and Scotland[6] found 187 definitions. They looked at the frequency of words used in definitions. ‘Physical’ was only present in 25%, and it was number 19 in terms of frequency.

One may conclude that adding physical cannot be justified, because:

- its focus on one aspect of treatment risks losing the holistic nature of rehabilitation
- there is no research into ‘physical medicine’ or ‘physical rehabilitation’
- it is not commonly used in definitions of rehabilitation and has no publicly recognised meaning.

**Specific comments on proposed advantages on adding physical**

The proposal ends [our response is given in the following bullet point]
"*In summary, by changing our name to British Society of Physical and Rehabilitation Medicine we will:*

- *Bring our Society in line with the rest of the world and foster growth in our workforce, so that we meet the international standards and deliver the medical workforce needed to manage people with disability. Currently we are at 10% strength: 0.2 consultants/100,000 whereas we need to be 2/100,000.*
- We agree that the workforce is inadequate. There are no calls from the public or from rehabilitation societies for a change of name of this Society to overcome this. The proposers do not explain how changing the name of the Society will lead to more funding for rehabilitation.
- *Break the stagnation that our workforce has endured, recognising that other medical specialties have grown more than 3 times faster over the past decades*.
- The number of consultants and trainees in every speciality is determined by the Department of Health. A change in the name of the Society will not influence the Department of Health. Not much does.
- *Bring back Musculoskeletal Medicine to the society, which we lost even though MSK problems are the single largest cause of disability in any population.*
- It is true that Sports and Exercise Medicine was founded and potentially sees patients with musculo-skeletal problems. The speciality's foundation was a political decision, related to the Olympics, resisted by almost everyone. In reality their consultants do not see many more patients than this speciality does, and Rehabilitation Medicine consultants do see patients with Musculo-skeletal disorders. Most patients with straightforward problems are managed by physiotherapists and a name change will not alter that.
- *Encourage our peers from outside the UK to work in clinical posts which we have constantly failed to fill, and reduce the risk of losing even more posts due to failed recruitment.*
- Many people from outside the UK currently move here to work. Many need to gain a much broader experience of rehabilitation before gaining their CESR.
- *Give us a broader, fresher outlook and allow us to work collaboratively with peers outside the UK on educational, clinical and research projects*.
- We already work collaboratively with rehabilitation professionals from around the world. Collaboration arises from expertise, not the name of this Society.

**Professor Derick Wade**
**Professor of Neurological Rehabilitation and Consultant in Rehabilitation Medicine**

**Dr Sara Ajina, Consultant in Rehabilitation Medicine**

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