INTERNATIONAL SOCIETY OF PHYSICAL AND REHABILITATION MEDICINE

THE RESULT OF THE MERGER AND INTEGRATION OF IRMA AND IFPMR

NEWS & VIEWS – DECEMBER 2005

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The eve of a New Year is the perfect moment to reflect on the successes and experiences acquired during the last twelve months and to draw some conclusions.

It is also the perfect moment for making plans for the future – and for renewing hopes and dreams.

Thank you for working with us this year!

Accept our best wishes for a successful, happy and healthy 2006.

Let us keep on fighting together to promote our specialty!

Prof. Linamara R. Battistella, MD, PhD
President
International Society of
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INTERNATIONAL SOCIETY OF PHYSICAL AND REHABILITATION MEDICINE

THE RESULT OF THE MERGER AND INTEGRATION OF IRMA AND IFPMR

NEWS & VIEWS – DECEMBER 2005

PHYSICAL MEDICINE AND REHABILITATION, THE SPECIALTY OF THE THIRD MILLENIUM

By Prof. Linamara R. Battistella, MD, PhD

Physiatry is the reflection of the holistic vision of health. Beginning with the advances of pharmacology, immunology, clinical treatment in general and of the diagnostic arsenal, Medicine has managed to save many lives. However, this increase in survival was accompanied by an ever-greater contingent of people with a greater or lesser degree of disability, who cannot, after their cure, be reintegrated to the workplace, to community life or even to their own independence for self-care.

In order to allow the recuperation of biological integrity, adequate functioning and the complete participation according with social expectations, as well as the return of the individual to conditions prior to his disability, Physical Medicine and Rehabilitation is usually requested. However, the experience acquired during wars and the epidemics of infectious diseases show that society should respect differences and reward the efficiency of each human being in the development of action, which may be realized in a special manner and even assisted, however with the same final result.

In order to offer social inclusion to handicapped people, it is necessary that the patient receive comprehensive assistance which will limit and reduce the primary disability, prevent secondary disabilities and guarantee clinical and technical mechanisms which allow this patient to use all of his remaining potential.

A timely example is a young man with spinal cord injury. There is no way to avoid paralysis and neurogenic bladder. However it is essential to prevent repetitive infections, pressure sores, cardiovascular and metabolic disturbances due to immobility and the psycho-affective alterations; and a therapeutic program which assists locomotion, self-care, return to community life and the guarantee of work or the generation of income must be established.

This task, supported by the clinical conditions of the patient and with family and social support, should be developed by a specialized and trained team within the interdisciplinary concept.

Both national and international medical organizations are familiar with the concept that the physiatrist is the medial specialist who is best prepared to understand the multiple clinical characteristics of the disabled patient, as well as the varied problems that they face in daily life. This wide approach to these patients is performed with a specific arsenal of therapeutical procedures and instruments. Clinical stability is a basic need of any subject under therapy, even more in rehabilitation patients, who will not be able to follow a series of physical or cognitive tasks unless under optimal conditions.

It must be recognized that competence in Physiatry is necessarily linked to competence in general practice directed to the transitory or definitely incapacitated patient. There is also a consensus that this professional is trained to attend this patient who may have developed either an incapacitating injury or an installed disability. On the other hand, there is a need to prevent, treat or limit all phenomena that interfere with the motor function, recuperating movement for the correct application of functional activities of daily life, of locomotion, in the profession and in the social performance of this patient.

Physiatry is the medical specialty for the handicapped, it is responsible to define the hierarchy of procedures, give instruments to the other specialists regarding the approach to this patient and study the dynamics of a team able to offer him the care necessary from the point of view of the acute phase of the injury. In order to avoid secondary effects of injuries and disabilities arising from the illness itself, and of accompanying this patient up to discharge, to evaluate the necessity and the opportunity for being recommended to the Rehabilitation outpatient center.

The correlation which effectively exists between General Practice and Rehabilitation Medicine allows us to refer to some of the principles dictated by various organizations regarding competence in general practice, carrying these principles into Rehabilitation Medicine:

INTERNATIONAL SOCIETY OF PHYSICAL AND REHABILITATION MEDICINE

THE RESULT OF THE MERGER AND INTEGRATION OF IRMA AND IFPMR

NEWS & VIEWS – DECEMBER 2005

1. Knowledge of the basic scientific foundations of general practice, taking into account that up-to-date medicine is a science, in its basics and method of teaching;
2. Aptitude for collecting data, with a view to formulating diagnostic hypotheses: develop the capacity of collecting elements through the interview and physical examination, and to study these elements, to pass on the solution to the problem of the functional diagnosis and prognosis;
3. Critical judgment in the selection of complementary tests and the capacity to interpret the results. It is indispensable, with the large number of tests available, some highly complex and extremely costly, that these tests should be requested with discernment;
4. Aptitude for applying methods of epidemiology in studies and clinical practice, considering frequency of illnesses, etiology, risk factors, clinical measures, necessity to take into account cost-benefit in decisions as to functional diagnosis and rehabilitation therapeutics;
5. Judgment as to the opportunity of referral to other specialists. The good general training of the Physiatrist will allow him to resolve the majority of problems, without the necessity of referring the patient;
6. Integral understanding of the patient and of his inter-relations with the family and the environment, showing the need for global evaluation, as to psychosomatic aspects and in the influence of social, occupational and environmental factors in the evolution of illnesses;
7. Aptitude to carry out the most common invasive procedures, such as myofascial trigger-point inactivation, paraspinous blocks, neuromuscular blocks and vesical catheterization;
8. Preparation for the relationship with the patient and his family in humanitarian and ethical terms. The teaching of ethics and bioethics, resulting from scientific and technological progress is one of the most important aspects and, nevertheless, most neglected in modern medical teaching;
9. Aptitude for teamwork. The training in this sense should begin early, in the graduate phase, so that the student will cultivate work habits together with and in respect to other health professionals;
10. Knowledge of community health problems and the awareness of the social commitment of the doctor. This quality reflects the participation of the Physiatrist in what is considered, today, fundamental, or rather, the responsibility of the medical school toward society and the awareness of the community in general about the real possibilities of the handicapped person;
11. Training for specific diagnostic activities that involve eletrophysiology of the muscles and nerves (classical electrodiagnosis, eletroneuromyography and evoked potentials) dynamic evaluation of movement and dinamometric assessment.

Medical practice in the Area of Rehabilitation requires command of a great many specific areas of knowledge and, for this reason, requires a long period of training, specialization and permanent updating. Among the fundamental areas of knowledge we can mention: disability epidemiology, functional evaluation and diagnosis, profound knowledge of the anatomy, physiology and pathology related to the function. Also required are profound knowledge of the principal conditions that create disability and preventive, diagnostic and therapeutic measures directed toward these conditions, full knowledge of the field of action of the team of professionals to be involved and having their action optimized in the process of rehabilitation, command of the use of therapeutic measures intended for the rehabilitation of the disability, qualification to prescribe and orient the adequate use of orthoses, prostheses and auxiliary means of movement.

Lastly, the procedures that involve a specialty should be highly regarded and definite as to diagnostic or therapeutic resources and it should be understood that the therapeutic resource alone does not define a specialty. However, it must, for the patient's own safety, be applied exclusively by the specialist or supervised by him, since the therapy must presuppose knowledge of the pathology and of the associated problems, effects, side-effects, and limitations of its applicability.

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THE RESULT OF THE MERGER AND INTEGRATION OF IRMA AND IFPMR

NEWS & VIEWS – DECEMBER 2005

OPERATION FUNCTIONAL RECOVERY: THE INTERNATIONAL REHABILITATION COMMUNITY UNITES TO HELP HURRICANE SURVIVORS

By: Mark A. Young MD, MBA, FACP, Chair, International Exchange Committee, ISPRM - markyoung123@gmail.com

Three long and hard months have passed since Hurricane Katrina brought death and destruction to the residents of New Orleans, Mississippi and the Gulf Region. The world had barely been recovering from earlier natural disasters such as the Tsunami in South Asia and East Africa as well as the cataclysmic earthquakes in Turkey and Pakistan when Hurricane Katrina vengefully hit American shores in late August.

As a first hand observer of Hurricane Katrina who has been asked by my government to play a leadership role in the rehabilitation recovery effort, I would like to share my reflections and observations with fellow members of ISPRM, since I believe that there are many important lessons to be learned about rehabilitation's potential vital role in international disasters and our unique opportunity as a specialty to "make a difference" through global team work and collaboration.

Hurricane Katrina & Operation Functional Recovery: Background & Timeline

Within days of the Hurricane, I was personally contacted by my government to lead a national humanitarian effort to set up a unified rehabilitation response to address the medical and therapeutic needs of Katrina's survivors. Persons with disability and citizens in wheelchairs and folks in chronic care facilities and nursing homes were in dire jeopardy and rehabilitation' powerful input was sorely needed... Working together closely with Professor Mathew Lee, Chair of Rehabilitation at the Rusk Institute, New York University in New York and other institutions and professional organizations, we labored fast and furiously to assemble a group of rehabilitation focused disaster response teams composed of concerned and skilled interdisciplinary rehabilitation professionals. With the encouragement of Dr. Margaret Gianinni, Director of the Office of Disability for United States Health and Human Services Department and the US Surgeon Generals Office, we were able to successfully rally the help and support and active participation of the rehabilitation community. Named, "Operation Functional Recovery", our humanitarian efforts centered on addressing the unique rehabilitation needs that Hurricane survivors faced in the aftermath of the destruction.

Rehabilitation volunteers sought were dedicated groups of men and women who pledged a willingness to serve both locally in the Hurricane torn Gulf Region performing clinical relief tasks as well in their home towns assisting with administrative and logistical details. Recognizing the vast reach of our specialty, I decided to organize this gargantuan team building effort around 6 fundamental "core competencies" and to assign volunteers to one or more of these groups based on their declared interest and proven aptitude:

Operation Functional Recovery Volunteer Groups:

- Skin and Wound Management
- Neurological Rehab
- Geriatric Rehab
- Pediatric Rehab
- Pain Management
- Psychological Rehabilitation

Our initial "call to action" was disseminated in the "Advance for Directors in Rehabilitation" Journal in September: http://rehabilitation-director.advanceweb.com/common/Editorial/Editorial.aspx?CC=59070

"Operation Functional Recovery": A Three Month Retrospective Review

In the three months since Operation Functional Recovery was initiated, over 450 volunteers from across the rehabilitation spectrum including physiatrists, PT's, OT's, SLP's, Nurses, Orthotics and Prosthetics, Nutritionists and Psychologists and others have enlisted with Operation Functional Recovery (OFR) to meet the emerging functional and rehabilitation needs of Katrina survivors. Generous offers to volunteer have not been limited to the United States but have come from come from far and wide, and locations abroad including Holland, Canada, Israel, Cuba, Portugal and Turkey.

INTERNATIONAL SOCIETY OF PHYSICAL AND REHABILITATION MEDICINE

THE RESULT OF THE MERGER AND INTEGRATION OF IRMA AND IFPMR

NEWS & VIEWS – DECEMBER 2005

Pre-Deployment Rehabilitation Planning and Ground Work
In preparation for the humanitarian ground efforts, OFR has held multiple planning and tactical meetings to assure a true "team response". The inaugural meeting took place on Friday, September 15th, 2005 chaired by Dr. Mark Young. Participants in the teleconference included ranking representatives of major rehabilitation organizational leadership including AAPM&R. APTA, AOTA, ASLPA, APMA and NIEI.

A follow up regional planning meeting was held in Harlem, New York on Sunday, September 18th at the New York College of Podiatric Medicine, chaired by ISPRM members Dr. Mark Young, Dr. Bryan O'Young and David Cassius MD in which deployment plans and a blueprint for cross disciplinary rehabilitation collaboration was drawn. Also present at this crucial planning meeting were a multi-specialty constellation including Dr Stanley Kornhauser, (NIEI), Sue Eisenberg (RN), Harriet Duffy (OT), Lisa Anderson (PT), and Jessica Gross (OT). Alice Quaid (OT), an OT from Metairie, Louisiana was available via teleconference and provided her personal account of the hurricane's devastating blow and its impact on rehabilitation and people with disabilities.

Many other Operation Functional Recovery activities have taken place, in the weeks since Katrina. Individual pre-conference briefings were held with regional pain management authorities including Dr. Andrew Fischer and Dr David Siegel (Both ISPRM members) on the issue of optimizing Pain Management Humanitarian Services for Katrina Survivors and with physical therapy academic leaders. Discussions about establishment of a Rehabilitation & Psychology Crisis Telephone Hotlines for Katrina survivors were held with academic leaders in the psychology and disaster management trades. The feasibility of creating an online functional deficit and disability data registry was discussed with Rehabilitation informatics specialists. A centralized e-mail portal has been created and is operational. An OFR web site is currently being constructed and volunteer help is being sought.

Offers of endorsement and moral support have been widely forthcoming for Operation Functional Recovery from all across the rehabilitation continuum. The NYU Medical Center and the Rusk Institute pledged to allocate 5 beds for Katrina survivors. Many other CARF facilities have done so. Additionally, PM&R resident training programs at NYU RUSK as well as other leading programs have explored special provisions for "displaced" Tulane and LSU physicians and rehabilitationists in training. Offers of endorsement from the Healthy Living Forum and Rusk Without Walls, two non-profit organizations have been received.

Operation Functional Recovery: The November Deployment:
A deployment of volunteers took place in November 2005 when several of our dedicated interdisciplinary volunteers conducted an on-site needs assessment and a fact finding mission. The advice and recommendations of several of our international colleagues was sought in order to plan an effective mission, since it had been only a few months earlier that some of our ISPRM colleagues had gained first hand experience with the Tsunami and other natural disasters. Despite the difficulty in locating areas of greatest need and obtaining rehabilitation access and clearance within New Orleans and the surrounding "Hurricane Belt", our information gathering and fact finding mission was successfully conducted in a variety of venues including clinics, hospitals, Shelters and assistive living facilities that had been hard hit by Hurricane Katrina in New Orleans, Mississippi and the Gulf Region. The needs assessment initiative conducted during the November deployment involved the input of several ISPRM members: Dr. Bryan O'Young, Dr. David Cassius, Dr. Mark Young, and Dr. David Siegel. In addition many interdisciplinary rehabilitation team members took part including Dr. Charles Ross DPM, Lisa Schuler PT and Dr. Chantal Lorio DPM. Physical destruction of Katrina was evident where ever we went. See Photos: (link)

Operation Functional Recovery November Mission: Observations & Lessons Learned
1) Although many traditional "medical patients" were evacuated from New Orleans and the Gulf region in the early days after the Hurricane, there are still many persons with disabilities who continue to remain in the area.
2) Due to the hardship and difficulty associated with evacuation procedure for people with functional deficits associated with their disability (mobility impairments, visual impairments, communication disorders) a significant number of people elected to stay close to home, rather than relocate.

INTERNATIONAL SOCIETY OF PHYSICAL AND REHABILITATION MEDICINE

THE RESULT OF THE MERGER AND INTEGRATION OF IRMA AND IFPMR

NEWS & VIEWS – DECEMBER 2005

3) Existing rehabilitation facilities face a staff crisis due to the mass migration of core staff members out of the area. Services most profoundly affected include rehabilitation support staff such as certified rehabilitation nursing, general nursing, therapy and physiatric services. Facilities are very open to hiring new staff to replace lost staff. Rehabilitation specialists (especially nurses) interested in opportunities can send an e-mail to katrinarehab@gmail.com.
4 Rehabilitation patients with diabetes, peripheral neuropathies, pain and peripheral vascular disease who suffer from chronic wounds have been hard hit by the Hurricane due to a variety of exacerbating factors including loss of glucometer monitoring devices and suboptimal environmental conditions.
5 Many diabetic patients needed to flee their homes without their protective diabetic footwear and many have no shoes to protect their feet. Diabetic glucometers were destroyed by the flooding.
6 In some circumstances mobility deficits have become exacerbated in patients with lower extremity wounds. People have suffered not only physical but also psychological set backs from the Hurricane. Chronic painful conditions have become magnified.
7 People with traditional neurological conditions (stroke, spinal cord injury, MS) continue to face challenges after the Hurricane.
8 Establishment of disability specific evacuation procedures and guidelines (for future disasters) remains a big priority to be addressed by the international rehabilitation community.
9 Rehabilitation's team orientation and philosophy of "sharing and caring" can make a difference in this disaster and other international calamities. The need for Physical Medicine & Rehabilitation team intervention in the aftermath of the hurricane continues to exist.
10 Continued collaboration among members of the international rehabilitation community during times of crisis will touch the lives of the patient's we serve.

Future issues of News and Views will contain an update. In the meantime, I welcome your input.

THE WHEELCHAIR SKILLS PROGRAM: RATIONALE, EVIDENCE AND APPLICABILITY TO THE INTERNATIONAL CONTEXT

By R. Lee Kirby, MD, Division of Physical Medicine and Rehabilitation, Dalhousie University, Halifax, Nova Scotia, Canada
Email: kirby@dal.ca

The Wheelchair Skills Program (WSP) is comprised of the Wheelchair Skills Test (WST) and the Wheelchair Skills Training Program (WSTP).[1] The measurement properties of the Wheelchair Skills Test (WST) have been well documented.[2,3] In these studies, the WST was found to be safe, practical, reliable, valid and useful. The WST has been used as a screening or outcome measure in a number of studies. Further study is needed to evaluate the measurement properties of the WST as it evolves, and in different settings.

The relationships between the objective WST and the questionnaire version of the WST (WST-Q) have also been reported.[4,5] The correlations between the total WST and WST-Q scores were found to be excellent, although the WST-Q scores were slightly higher.

Regarding the Wheelchair Skills Training Program (WSTP), we have completed two randomized controlled trials on wheelchair users, one on wheelchair users admitted for initial rehabilitation[6] and one on wheelchair users in the community.[7] In both, we found that the WSTP was safe, practical and resulted in significantly greater improvements in wheelchair skills performance than standard care. In a third randomized controlled trial, on occupational therapy students, we found that the WSTP resulted in significantly greater improvement in wheelchair skills than a standard undergraduate occupational therapy curriculum[8] and that these skills were retained 9-12 months later.[9] Finally, in a recent pilot study in a rehabilitation centre,[10] we provided less than 50 minutes of training on wheelchair-handling skills to caregivers of wheelchair users. We found that the WSTP was an effective way to improve caregiver skills and that these skills were retained.

INTERNATIONAL SOCIETY OF PHYSICAL AND REHABILITATION MEDICINE

THE RESULT OF THE MERGER AND INTEGRATION OF IRMA AND IFPMR

NEWS & VIEWS – DECEMBER 2005

To date, we have studied over 500 people (wheelchair users, caregivers, occupational-therapy students and other non-wheelchair users), many of them on two or more occasions. Studies of the safety and effectiveness of the WSTP in other settings are planned. Although the WSP remains a work in progress, the evidence accumulated to date suggests that the WST is a reliable and valid testing tool, that the WSTP is a low-tech but high-impact intervention, and that it has potential to help the mobility and participation of wheelchair users in a broad range of settings.

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5. Mountain AD, Kirby RL, Smith C. The Wheelchair Skills Test: validity of an algorithm-based questionnaire version. Arch Phys Med Rehabil 2004;85:416-23.
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10. Kirby RL, Mifflen NJ, Thibault DL, Smith C, Best KL, Thompson KJ, MacLeod DA. The wheelchair-handling skills of caregivers and the effect of training. Arch Phys Med Rehabil 2004 85:2011-9.

NEWS FROM OUR MEMBERS

Society Websites

- The new website of the Belgian Society will be available at **www.prmbelgium.be** from January 1st onwards.
- The website of the Italian Society has been refurbished and can now be found at **www.simfer.ntc.it**

Appointments

The Italian Society of Physical Medicine and Rehabilitation has appointed a new Board during its recent meeting in Catania.
Prof. Raffaele Gimigliano has been appointed as the new SIMFER President. He is professor in PM&R at the Faculty of Medicine and Surgery of the Second University of Naples and is the author of beyond 200 articles in national and international reviews. He also has cured the publication of the volume: "La riabilitazione nel 3° millennio" EdiErmes, Milan, 2000

In this section of the News & Views, appointments for head of PM&R departments, regional ones, new services, etc., from all over the world will be published. So feel free to send your information to the Central Office for publication in the next issues of the News & Views.

INTERNATIONAL SOCIETY OF PHYSICAL AND REHABILITATION MEDICINE

THE RESULT OF THE MERGER AND INTEGRATION OF IRMA AND IFPMR

NEWS & VIEWS – DECEMBER 2005

Job opportunities
The Murwillumbah District Hospital of the North Coast Area health Service in Australia is looking for a staff specialist in Rehabilitation Medicine (Position MB2005/019) – more details at www.ncahs.nsw.gov.au/employment.

If you have any job opportunities, please inform the ISPRM Central Office so that they can be published in this section.

MEMBERSHIP RENEWAL

At the beginning of this week, you will all have received an invitation to renew your ISPRM membership for the year 2006. This invitation came in a new way with a personalised email and all your personal data in the body of the email (except credit card information). The advantage of this kind of renewal invitation is that you need not fill out the form annually again.

We are very glad to see that a lot of our members immediately replied and renewed their membership for 2006 already. If you should not have received our email invitation for membership renewal (or if it should be lost) please notify the Central Office.

WEBSITE WAS DOWN RECENTLY

Due to some technical problems the website has been down for some days. This problem has been solved meanwhile but apparently our website still has problems with forwarding emails that are sent to the xxx@isprm.org email addresses.
If you wish to contact the Central Office, use the email address werner@medicongress.com instead. If emails were sent to the isprm.org email address recently and you did not get a reply, we kindly ask to forward them again to the above email address. This email problem should be solved in the upcoming days as well.

NEWS & VIEWS EDITORIAL BOARD

The ISPRM News & Views Editorial Board consists of:

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Please feel free to submit articles for the News & Views and to take part in our Editorial Board.

INTERNATIONAL SOCIETY OF PHYSICAL AND REHABILITATION MEDICINE

THE RESULT OF THE MERGER AND INTEGRATION OF IRMA AND IFPMR

NEWS & VIEWS – DECEMBER 2005

UPCOMING MEETINGS AND CONGRESSES

Congresses with the ISPRM logo are endorsed by the ISPRM and offer reduced fees to ISPRM Members

- Congresses on **Stroke** http://www.internationalstroke.org/s_content.php?id=fb2002-03-04-1020
- Congresses on **Neurology** http://www.eurostroke.org/esc_main%20links.htm
- Congresses on **PM&R** http://www.prm-calendar.org/Default.aspx

4th ISPRM World Congress – June 10 - 14, 2007 in Seoul, Korea – www.isprm2007.org

5th ISPRM World Congress – May 9 – 13, 2009 in Istanbul, Turkey

6th ISPRM World Congress – June, 4 – 9, 2011 in San Juan, Puerto Rico

- **Cognitive Rehabilitation Workshop**, Instructors: Kit Malia & Anne Brannagan, 20-21 January 2006, Location: Gatwick Hilton, Gatwick Airport, UK- visit www.braintreetraining.co.uk
- **34th Annual Conference of the Indian Association of Physical Medicine and Rehabilitation,** 20-22 January 2006, Mumbai, India. Contact vamaevents@yahoo.co.in
- **Update: Body Weight Support Treadmill Training in Neurological Rehabilitation:** discussion with International Experts. Parma (Italy), January 26th-27th, 2006; language: English and Italian. Information: www.simfer.it; afanti@ao.pr.it
- **International Conference on Aging, Disability and Independence,** 1-5 February 2006, St. Petersburg, Florida USA www.icadi.phhp.ufl.edu
- **ICF User Forum** 6-7 February 2006, Sydney, Australia - contact: sally.bullock@aihw.gov.au
- 4th **World Congress of Neurorehabilitation**, Hong Kong, 12-16 February 2006, visit www.wcnr2006.com
- **6th Annual Rehabilitation Educators Conference,** Strengthening the Continuum of Rehabilitation Practice and Research in a Global Environment, 16-19 February, 2006, San Diego, California, USA, Contact: Dr. Charles Arokiasamy +1-559-278-0158
- **Lower Limb Prosthetics & Amputee Rehabilitation Course**, 20-24 February 2006, Royal Melbourne Hospital, Melbourne, Australia, contact nicholas.freijah@mh.org.au
- **World Parkinson Congress**, 22-26 February 2006, Washington. USA, Contact: info@worldpdcongress.org
- **42nd Annual AAP Educational Conference of the Association of Academic Physiatrists,** 1- 4 March 2006, Daytona Beach, USA – visit **www.physiatry.org**
- **Dubai International Rehabilitation Forum (REHAB) 2006;** 7-9 March 2006, Dubai International Exhibition Center - visit www.rehab.ae

INTERNATIONAL SOCIETY OF PHYSICAL AND REHABILITATION MEDICINE

THE RESULT OF THE MERGER AND INTEGRATION OF IRMA AND IFPMR

NEWS & VIEWS – DECEMBER 2005

- **17th National Congress with international participation: Pain in Rehabilitation Medicine**, 17 & 18 March 2006, Ljubljana, Slovenia – Contact marincek.crt@mail.ir-rs.si
- **Nancye B Holt Annual Rehab Management course**, 30-31 March, Rehab Inst of Chicago, USA. Visit www.ric.org/education
- **2ND Int Cancer Rehabilitation Conference**, 30 March-1 April, Vancouver, Canada, Contact: ipconf@interchange.ubc.ca
- **1ST Int Conference on Hypertension, Lipids, Diabetes and Stroke Prevention**, 30 March-1 April, Paris, France. Visit www.kenes.com/strokeprevention
- **26th Annual Scientific Meeting of the Australian Pain Society**, 9-12 April 2006, Grand Hyatt Hotel, Melbourne, Australia. visit www.apsoc.org.au

3rd State of the Art in Chronic Low Back Pain, by Prof Henk Stam, Erasmus University, 9-12 April 2006, Bodrum, Turkey, info: www.vitalmedbodrum.com

- **3rd State of the Art in Chronic Low Back Pain**, by Prof Henk Stam, Erasmus University, 9-12 April 2006, Bodrum, Turkey, info: www.vitalmedbodrum.com

- **Stroke Rehab 2006 – Evidence for Stroke Rehabilitation – Bridges into the Future,** April 26-28, 2006, Goteburg, Sweden – contacttgunnar.grimby@rehab.gu.se or www.congres.se/stroke2006
- **14th Annual Meeting of the Australasian Faculty of Rehabilitation Medicine (AFRM)**, 2-5 May 2006, Cairns, Australia, visit: www.racp.edu.au/afrm
- **15th European Congress of Physical Medicine and Rehabilitation**, 16-20 May 2006, Madrid, Spain. Visit www.ecprm2006.com
- **XXXIV SIMFER National Congress,** Movement and autonomy: assessment and techniques. June 4 – 7, 2006, Florence, Italy – Main language Italian – Visit: www.simfer.it
- **35th Congress of the Int Society of Medical of Hydrology and Climatology – Rehabilitation in Spa's and Health Resorts,** 6-10 June 2006 in Istanbul, Turkey, visit www.ismh2006.com
- **ISSLS** 2006, Annual Congress of the **International Society for the Study of the Lumbar Spine**, 13-17 June 2006, Bergen, Norway, Contact: issls@medicongress.com – www.issls.org
- **32nd Annual Scientific Meeting of the American Spinal Injury Association (ASIA) and the International Spinal Cord Society (ISCoS),** 25-28 June 2006, Boston, MA, USA. Visit www.asia-spinalinjury.org/annualmeeting
- **XXX Congresso Brasileiro de Medicina Fisica e Reabilitacao**, 12-15 July 2006, Belo Horizonte, Brazil: visit www.rhodeseventos.com.br
- **World Congress on Medical Physics and Biomedical Engineering**, 27 August-2 September, Seoul; Korea. Visit http://wc2006-seoul.org
- **XVI Congress of the Ecuadorian Society of PM&R,** 11-15 September 2006, Guayaquil, Ecuador, contact Gustavo Bocca Peralta at gwbocca@hotmail.com

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NEWS & VIEWS – DECEMBER 2005

- **131st Annual Meeting of the American Neurological Association,** 08- 11 October, 2006, Chicago, IL, USA, http://www.aneuroa.org/annual.htm
- **5th Int. Congress on Spondyloarthropathies,** 12-14 October 2006, Gent, Belgium, Visit www.medicongress.com

6th Mediterranean Congress of PM&R, 18-22 October 2006, Marina Hotel, Vilamoura, Portugal. Visit www.the.pt

- **22nd Congress of the Latin-American Medical Association**, November 8-12, 2006, Veracruz, Mexico, contact jmguzman@avantel.net
- **68th Annual Assembly of the AAPMR**, 9-12 November 2006, Honolulu, Hawai, USA – www.aapmr.org
- **Joint World Congress on Stroke**, 22 – 25 November 2006, Capetown, South Afrika – visit www.kenes.com/stroke2006
- **4th International Congress of the Cuban Physical Medicine and Rehabilitation Society**, March 26-30, 2007, Havana, Cuba - visit www.sld.cu/sitios/rehabilitation or contact jorge.martin@infomed.sld.cu
- **12th World Congress of the International Society for Prosthetics and Orthotics**, July 29 - August 3, 2007, Vancouver, Canada. Visit: www.ispo.ca/congress
- **9th Congress of European Federation for Research in Rehabilitation (EFRR) ,** 27 to 31 August 2007, Budapest, Hungary - Theme: "Partnership in rehabilitation research"- Contact: Prof. Lajos Kullmann, l.kullmann@rehabint.hu
- **69th Annual Assembly of the AAPMR**, 27-30 September 2007, Boston, USA – visit www.aapmr.org

EuroSpine 2007, 2-5 October 2007, Brussels, Belgium
Heizel Congress Center – visit: www.medicongress.com

- **Annual Congress 2007 SOFMER (French Society on PM&R)**, 4-6 October 2007, Rennes- St Malo, France – contact gdekorvin@cpa-sante.com

European Congress on Physical Medicine & Rehabilitation, 4 - 7 June 2008, Brugge, Belgium - visit www.medicongress.com

- **7th Mediterranean Congress of Physical and Rehabilitation Medicine,** 18 - 21 September 2008, Potorose, Slovenia Contact: Prof. Crt Marincek marincek.crt@mail.ir-rs.si
- **European Congress on Shoulder Surgery – SECEC 2008**, 18-20 September, Brugge, Belgium – visit www.medicongress.com
- **70th Annual Assembly of the AAPMR**, 20-23 November 2008, San Diego, USA – www.aapmr.org
- **AMLAR 2008**, November 2008, Punta Del Este, Uruguay – www.surmedfi.org.uy

Please feel free to send us an email with your upcoming congresses for insertion in this agenda

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