THE INDIAN SOCIETY OF PM&R (IAPMR)

Dr. Thuppal Sreedhar
Secretary to the Indian Association of PMR

There are 350 physiatrists in India. After passing out the graduation in Medicine and internship, a medical graduate has to undergo training in the Dept of Physical Medicine and Rehabilitation for 3 years before appearing for the final Exam and will get the MD in Physical Medicine and Rehab or they can appear for the National Board Examination from the recognised Rehab Institutes and will get the Board Certification.

There are 24 Medical Universities offering the PMR post graduation training and another 5 national centres giving training in PM&R. The need for Rehabilitation of Physically Disabled was the felt need for post world war II.

In 1954 Federal Govt has taken steps to train the specialists in Rehab and start educational centre ie AIIPMR where I am presently working as Physiatrist for the past 18 years.

The practicing Physiatrists felt the need to come together and registered the body in 1972 and the first Annual congress was held in Jan 1973 and was inaugurated by then President of India Mr. V V Giri. Thus IAPMR is born and every 2 years the Physiatrist elect the President and the Secretary, and every year the annual congress is held in a different part of the country.

It has instituted fellowships for young Physiatrists to visit intra-country Rehab centres for training. It has State chapters and to conduct CME programmes annually there are 16 such state branches and actively involved in academic activities.

This is in brief about IAPMR.

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THE 8TH NATIONAL CONFERENCE OF EXERCISE AND REHABILITATION MEDICINE HELD IN ZHUHAI, CHINA
By Jianan Li

The 8th National Conference of Exercise and Rehabilitation Medicine was held in Zhuhai International Convention Center Hotel, China during February 17 to 21, 2006. More than 400 physiatrists and therapists from 25 provinces of China attended the conference. The chairman of the conference is Prof Jianan Li and the Chairman of the local organizing committee is Prof Tiebin Yan. This is the first academic conference in China this year.

Six international experts including Prof Haim Ring (Israel), Prof Chang-Il Park (Korea), Dr. Marta Imamura (Brazil), Dr. John Olver (Australia), Dr. Sukajan Pongprapai (Thailand) and Dr. Leonard S.W. Li (Hong Kong), delivered their experience in latest advances of physical and rehabilitation medicine, which made this conference at high level.

The conference had obtained sponsorship from 26 companies from mainland China. The taskforce meeting of the Asia-Oceania Society of Physical and Rehabilitation Medicine (AOSPRM) was also held during the conference. Professor Sae-il Chun (Korea) chaired the meeting. Dr. Leonard S.W. Li (Hong Kong SAR) introduced major issues regarding to establishment of AOSPRM. Representatives from 14 Asia-Oceania countries attended the meeting. Meanwhile the Mini-Symposium on “Development of Rehabilitation Medicine in Asian/Oceania Region” was attracted many Chinese audiences.

The taskforce meeting decided that the AOSPRM will be established in the 4th ISPRM World Congress in Seoul in 2007 and the 1st AOSPRM conference will be held in Nanjing, China in 2008.
50TH ANNIVERSARY OF PHYSICAL AND REHABILITATION MEDICINE IN THE NETHERLANDS
By Daniël (Daan) Wever, MD.
President of The Netherlands Society of Physical and Rehabilitation Medicine - Website:http://vra.artsennet.nl

History
The official medical specialty Physical and Rehabilitation Medicine (PRM) has been in existence since 1955. So, the members celebrated the 50th anniversary of their specialty PRM in 2005. The development from physical therapy and rehabilitation medicine to PRM in the 20th century will be described. Gradually a methodical rehabilitation medical approach grew in the Netherlands. A systematic problem solving rehabilitation medical approach was described. It is based on a system with 5 fields of attention, SAMPC:

- somatic impairments=S
- activities of daily life=A
- social situation=M
- psychological condition=P
- communicative ability=C

The present
The International Classification of Functions (ICF), a model of impairments, activities and participation (World Health Organisation) is used nowadays. PRM is a comprehensive specialty:

- Concerned with all ages
- With a holistic approach, including social and environmental factors
- Dealing with varied and complex pathologies (spanning sports injuries to chronic progressive diseases)
- Based on biomechanics, neurobiology, effort biology, human sciences, information technologies.

PRM in the Netherlands is a treatment in which a team works interdisciplinary. PRM specialists play a core role inside health teams and networks. Multidisciplinary consultation is possible related to:

- Neurological rehabilitation
- Musculoskeletal medicine
- Spinal cord lesions
- Traumatology
- Amputations
- Paediatric rehabilitation
- Chronic pain rehabilitation

Medico-technical structures for in- and outpatients are possible:

- Functional assessment
- Orthotics and prosthetics
- Comprehensive rehabilitation, including technological aspects
- Vocational rehabilitation.

Modern tools in rehabilitation assessment are for instance:

- Gait, posture and movement analysis
- Kinematics and kinetic measurement
- Urodynamic evaluation
- Effort assessment and training
- Impact of impairment evaluation on functioning and quality of life.

PRM goals are physical, functional and social integration. These goals are individually set for each patient, give hope to all “lifetime events”, optimise a disabled child’s functional potential and utilise information technology in disablement.
PRM demography
In 2005 about 330 PRM specialists and 125 trainees are working in the Netherlands (with 16 million inhabitants) in about 25 rehabilitation centres and in about 100 (including 8 academic) hospitals all over the country. They all are members of the Netherlands Society of Physical and Rehabilitation Medicine (VRA).
There are 1400 rehabilitation beds for 7300 inpatients per year in The Netherlands. 45000 outpatients are treated per year. 7500 people are working in the rehabilitation field, among them 2250 nurses and 2250 paramedics. The costs are 250 million dollars per year.

Education and training
To become a specialist in PRM one has to follow a four-year-schedule. In the Netherlands there are about 15 training circuits spread over the country. Trainees can only follow the PRM education in an accredited centre or hospital. In the Netherlands Society of PRM there is an Educational Board that pays site visits to judge the accredited centres and hospitals and reports to the MSRC (Medical Specialists Registration Committee). Trainees can only start with their training when the MSRC has given an approval. There is an obligation to work for at least 1 year within a setting of clinical rehabilitation, 1 year policlinical rehabilitation, 1 year hospital rehabilitation and at least half a year rehabilitation of children. In those 4 years you must follow basic scientific courses about 4 times a year, mostly consisting of 2 days up to 1 week. After 4 years the trainee will get a registration as PRM specialist. Afterwards one has to be reregistered once in 5 years. Therefore one has to follow continuous medical education (CME) in PRM during 40 hours a year.
In the Netherlands there are 8 universities with a medical school. Together with a number of general hospitals and rehabilitation centres they play an important role in the education of medical doctors, trainees in PRM and CME.

Congresses
The Society of PRM has organised 2 world congresses in the last few years:

- World Congress of ISPO in 1998
- World Congress of ISPRM in 2001

Besides this our Society organises together with the British Society of PRM (BSRM) a combined congress every 5 years.

Research
Since 1990 a programme has been developed to improve the research abilities of PRM specialists. Since 1998 a programme for scientific research in PRM has been worked out, sustained by the Dutch government. This programme intends to assess existing research programmes and new initiatives and to give directions concerning coordination of the programmes and cooperation between the involved research institutes. This programme is financially supported by the government and by “Revalidatie Nederland” (Association of Rehabilitation Centres in the Netherlands). The financial support was 15 million dollars. In this way the quality of scientific rehabilitation medical research has to be improved and as a result of that scientific impact and value of the specialty PRM.
The 8 research themes were:

- Recovery of walking ability after a stroke
- Functional prognosis for patients with a neurological disorder
- Recovery of mobility in the treatment of patients with a spinal cord lesion
- Chronic low back pain
- Technical aids in rehabilitation
- Cognitive rehabilitation
- Rehabilitation for children
- Rehabilitation for elderly

As a consequence of these programmes there was an increase from 3 to 10 professors in PRM and from less than 10 to more than 60 PHD specialists in PRM especially in the last 15 years.

Summary
This short overview gives an impression of how in the Netherlands the specialty PRM developed from physical therapy and rehabilitation medicine to PRM nowadays. It needs interdisciplinary cooperation between professionals, skilled in rehabilitation and demands a high level of knowledge, experience and self-control not at the least of the PRM-specialist.

Although people with disabilities make up about 20 percent of the nation’s population, only a tiny fraction of medical school matriculants have disabilities. Why? First, let’s consider some relevant history from the AAMC itself.

In 1997, AAMC President Jordan J. Cohen, M.D., issued a moral charge to the medical profession. Writing in Academic Medicine, he called for “active steps to ensure that our health care practitioner community mirrors society’s gender, racial, and ethnic mix.” In a more recent essay, in the June 2004 AAMC Reporter, Cohen expanded the scope of the issue beyond considerations of race, ethnicity, and gender to include disability.

"Technological advances have made a host of things possible, both in medicine and in virtually every other walk of life, that were way beyond many people’s abilities not so long ago," Cohen observed. "Compelling examples of individuals, albeit still relatively few in number, with mobility, auditory, and visual disabilities who are valued members of the profession argue that it’s time to reconsider our traditional, often stereotypic, view of what it takes to be a capable doctor.”

Significantly, the recently released and widely supported "Compact Between Resident Physicians and Their Teachers," drafted by the AAMC, also includes the disability issue. Among 10 faculty commitments in the document is this one: "We will demonstrate respect for all residents as individuals, without regard to gender, race, national origin, religion, disability, or sexual orientation."

So why don’t we have more physicians with disabilities? In my experience, no American medical school has a "welcome sign" for individuals with physical disabilities. We need to do much more.

In an article in the January 2005 American Journal of Physical Medicine & Rehabilitation, I discussed the need to reassess our policies regarding physicians with disabilities and the physician workforce and made recommendations to the AAMC on how current policies could be changed to achieve this goal. I argued that medical schools’ core competencies and technical standards have not kept pace with technological changes, diverse specialization, and changing practice options.

A recent AAMC publication, "Medical Students With Disabilities: A Generation of Practice," offers the medical education community a practical guide for furthering its work with students with disabilities. But I believe that some of the report’s analysis and recommendations carry a negative and less-than-constructive tone. I am especially concerned about language meant to guide universities in their treatment of students with disabilities that could be better categorized as a guide to keep physically disabled applicants out.

One key issue concerns the so-called undifferentiated curriculum versus the undifferentiated student. I favor the undifferentiated curriculum.

Medical specialization has segmented the physician workforce — from a more homogenous group into one concentrating on specific body systems or disease entities. That is the reality of practice in the United States. My view is that significant differentiation of physicians into various specialties and subspecialties can serve as an argument for less rigidity in demanding that all students demonstrate competence in procedures that are not relevant to their expected practices.

The undifferentiated curriculum would allow students to meet competency requirements through multiple options, even including the role of physician extender, or mid-level health care provider. But I absolutely oppose using a tracking system, in which someone is admitted to medical school under the presumption that he or she will be designated to a specific postgraduate specialty. Each student must be handled on a case-by-case basis. The resident interviews by each specialty can handle that issue.

Clearly, admitting someone with a physical disability to medical school is controversial. In training competent physicians, we must protect both the well-being of all patients and the rights of all trainees. All medical students must have the appropriate intellectual capacity, ethical attitude, humanistic qualities, and desire to become doctors.

At the same time, we must respect creative solutions that people with disabilities often employ to perform tasks in alternate ways. The ability to perform the task at a defined level of quality should be emphasized, rather than the process by which the task is accomplished. We need to be flexible and consider what is possible through hard work and the use of technology.

The need for program modifications and reasonable accommodations differs for students, residents, and faculty members. A student’s focus is on educational requirements and on meeting the diverse demands of the basic sciences and clinical years. Faculty members with disabilities tailor their practices to minimize the need for accommodations, and organized medicine accepts and readily supports this.

Residency, however, is truly a mixture of service and education, and it offers perhaps the greatest challenges in terms of disability considerations. Residents may need to perform certain services essential to their residency program that are not necessary for students or faculty members. Even within a specialty, not all programs have the same “service” requirements. Should this work obligation be a barrier to satisfactory completion of residency training?

These issues must be studied; they will not go away. If diversity is an essential goal, as it should be, we must work to reach it. Otherwise, it could be said that we, as medical educators, are part of the problem.
UPCOMING MEETINGS AND CONGRESSES

- Congresses on Neurology: [http://www.eurostroke.org/esc_main%20links.htm]
- Congresses on PM&R: [http://www.prm-calendar.org/Default.aspx]


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

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

- 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]
- 14th Annual Meeting of the Australasian Faculty of Rehabilitation Medicine (AFRM), 2-5 May 2006, Cairns, Australia, visit: [www.racp.edu.au/afrm]
- 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]

• 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 Física e Reabilitação, 12-15 July 2006, Belo Horizonte, Brazil: visit www.rhodeseventos.com.br

• XIII National Congress of the Colombian Association of Physical and Rehabilitation Medicine (ASCMF&R), August 03-06, 2006, Cartagena de las Indias, Colombia. Contact: ascmfr@gmail.com or visit: http://rehabilitacion2006.homestead.com

• 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

• 131st Annual Meeting of the American Neurological Association, 08-11 October, 2006, Chicago, IL, USA, http://www.anepuroa.org/annual.htm

• 5th Int. Congress on Spondyloarthropathies, 12-14 October 2006, Gent, Belgium, Visit www.medicongress.com

• 3rd. Mitteleuropäischer Kongress für PM&R, organized by the German and Austrian Society in collaboration with the Italian Society on PM&R – Language German – 12 – 14 October 2006, CD-Hotel Salzburg. Info: pmr-kon@salk.at


• 22nd Congress of the Latin-American Medical Association, November 8-12, 2006, Veracruz, Mexico, contact jmguzman@avantel.net

• 66th Annual Assembly of the AAPMR, 9-12 November 2006, Honolulu, Hawai, USA – www.aapmr.org


• 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


• 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
**INTERNATIONAL SOCIETY OF PHYSICAL AND REHABILITATION MEDICINE**

**THE RESULT OF THE MERGER AND INTEGRATION OF IRMA AND IFPMR**

**NEWS & VIEWS – MARCH 2006**

- **EuroSpine 2007**, 2-5 October 2007, Brussels, Belgium
  Heizel Congress Center – visit: [www.medicongress.com](http://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](http://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


- **AMLAR 2008**, 3-6 November 2008 including the meeting of the Latinoamerican Society of Paraplegia, Hilton Conrad Hotel and Convention Center, Punta del Este, Uruguay – Contact Hugo Nunez Bernadet at anhunez@adinet.com.uy


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