



UEMS PRM Section and Board

EUROPEAN UNION OF MEDICAL SPECIALISTS
SECTION OF PHYSICAL AND REHABILITATION MEDICINE
EUROPEAN BOARD OF PHYSICAL AND REHABILITATION MEDICINE
UNION EUROPÉENNE DES MÉDECINS SPÉCIALISTES
SECTION DE MÉDECINE PHYSIQUE ET DE READAPTATION
COLLEGE EUROPEEN DE MEDECINE PHYSIQUE ET DE READAPTATION



Minutes OF THE GENERAL ASSEMBLY

Friday 8th – Saturday 9th September 2017

Venue: Hotel Sorea Regia, Bratislava (Slovak Republic)

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FRIDAY 8TH SEPTEMBER 2017

TIME OF THE WORKSHOPS

- 8.30 – 17.00 Workshops (Board, PPC and CAC)
lunch 13.00 – 14.00
14.00 – 15.00 *Foundation European College of physical and rehabilitation medicine
(general assembly of the board delegates)*
17.00 – 19.00 Balneology Meeting
Section Executive Committee meeting
19.30 Gala Dinner

2. AGENDA

2.1. AGENDA FOR THE UEMS-PRM SECTION BALNEOLOGY PERMANENT WORKING GROUP

1. Report from the Balneology Group Coordinator (Pedro Cantista)
2. ESPRM new Special Interest Scientific Committee (SISC) on Balneology
 - ESPRM collaboration - Scientific database – Research – Congress activities
3. Tasks of the Balneology Permanent Working Group (PWG)
 - Consensus between different countries regarding PRM and Balneology
 - Balneology Competence in Europe – The European Board
 - Core curriculum on Balneology for PRM Specialists
 - The new Pedagogic Balneology Unit in Vidago and its cooperation with our PWG
4. FEMTEC Congress 2017 presentation
5. ISMH Congress 2018 presentation

3. AGENDA OF THE UEMS PRM BOARD WORKSHOP

Chairpersons: M.G. Ceravolo, A. Juocevicius,
Secretary: Nikos Barotsis

3.1. PRESENTATION OF GUESTS AND NEW DELEGATES

M.G. Ceravolo



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3.2.CHANGES OF THE AGENDA AND APPROVAL OF THE MODIFIED AGENDA – M.G. CERAVOLO,

N. Barotsis

3.3.BOARD CERTIFICATION

3.3.1. ACTION PLAN 2014-18: GOALS AND STATE-OF-ART. –

M.G. Ceravolo

3.3.2. INFORMATION ABOUT THE BOARD EXAMINATION 2017

which will take place on 25th November 2017 –

M.G. Ceravolo, N. Barotsis

3.3.3. UPDATING THE QUESTION DATA BANK: TIPS FOR IMPROVING MCQ QUALITY.

R. Frischknecht

3.3.4. CERTIFICATIONS – SPECIAL OFFER ON THE OCCASION OF THE 25TH EUROPEAN BOARD EXAMINATION ANNIVERSARY -

N. Barotsis

3.3.5. CERTIFICATION OF TRAINING CENTRES –

A. Juocevicius

3.3.6. CERTIFICATION BY EQUIVALENCE: PROPOSAL FOR UPDATING REQUISITES

R. Frischknecht

3.3.7. CERTIFICATION OF TRAINERS –

R. Frischknecht

3.3.8. RECERTIFICATION OF FELLOWS –

A. Oral



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3.4. BOARD ACTIVITIES

3.4.1. ACTION PLAN 2014-18: GOALS AND STATE-OF-ART.

M.G. Ceravolo

3.4.2. EUROPEAN TRAINING REQUIREMENTS IN PRM

M.G. Ceravolo

3.4.3. CESMA REPORT –

R. Frischknecht, N. Barotsis.

3.4.4. CME/CPD ACTIVITIES AND ACCREDITATION OF SCIENTIFIC EVENTS –

J. Stanghelle

3.4.5. SUPPORT CONTINUING MEDICAL EDUCATION THROUGH TEACHING PROGRAMS AND EDUCATIONAL RESOURCES (E-BOOK, EBPRM PLATFORM)

M.G. Ceravolo, N. Barotsis

3.4.6. SCIENTIFIC SPONSORSHIP TO EDUCATIONAL EVENTS

R. Frischknecht, N. Barotsis

3.5. BOARD FINANCIAL ISSUES – W. JANSSEN

3.5.1. FINANCES 2017

3.5.2. SUBSIDIES FOR EUROPEAN SCHOOLS

3.5.3. BUDGET 2018

3.6. DUTIES OF NATIONAL MANAGERS (NM'S) –

Information for new NM's by F. Dincer, coordinator of NM's

4. AGENDA OF THE PROFESSIONAL PRACTICE COMMITTEE WORKSHOP

President: Enrique Varela Donoso

Deputy Secretary: Carlotte Kiekens



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4.1.E- BOOK ON FIELD OF COMPETENCES PART II, OVERVIEW AND STATE OF ADVANCEMENT OF THE ONGOING EBPPS.

4.1.1. ONGOING PAPERS:

- | | |
|-----------------------|---|
| 1) Pain | Gabor Fazekas |
| 2) TBI | Klemen Grabljevec |
| 3) Stroke | Ayse Kucukdeveci (Katharina Stibrant Sunnerhagen) |
| 4) SCI | Annie Rapi |
| 5) Progress./neurodeg | Maria-Gabriella Ceravolo |
| 6) N-MD | Rolf Frischknecht |
| 7) Cardiovascular | Alvydas Juocevicius/Aydan Oral |
| 8) Respiratory | Aydan Oral /Alvydas Juocevicius |
| 9) Oncological | Ayse Kucukdeveci |
| 10) Limb loss | Carlotte Kiekens |
| 11) CP | Karol Hornacek |
| 12) Pregnancy | Carlotte Kiekens |

4.1.2. FINISHED PAPERS IN THE COURSE OF PUBLISHING (VOTED IN MUNICH)

- | | |
|------------|------------------|
| a. Obesity | Paolo Capodaglio |
| b. Ageing | Aydan Oral |

4.1.3. PUBLISHED PAPERS

- Methodology
- Spinal deformities

4.2.MJC INFORMATION

4.2.1. PAIN MEDICINE

(Daan Wever and Nicolas Christodoulou)

4.2.2. SPINE SURGERY

(Stefano Negrini)

4.2.3. MANUAL MEDICINE

(Jiri Votava)



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4.2.4. SPORTS MEDICINE

(Nicolas Christodoulou)

4.3. PARTICIPATION OF PPC IN THE:

4.3.1. EUROPEAN CONGRESS IN VILNIUS WITH A SESSION OF 240 MIN (4 HOURS).

4.3.2. ISPRM CONGRESS IN PARIS.

4.4. COLLABORATION WITH UKRAINIAN COLLEAGUES

(Alvydas Juocevicius / Nicolas Christodoulou/volodymyr golyk)

4.5. STANDARDS FOR PRACTICE IN EUROPE. STATE OF THE ART AFTER PRAGUE MEETING

(Rajiv Sign)

4.6. COCHRANE COLLABORATION

(Stefano Negrini and Carlotte Kiekens)

4.7. WHITE BOOK OF PRM IN EUROPE

(Stefano Negrini)

4.7.1. DISCUSSION ON CHAPTER 0 AND DICTIONARY AND PREPARE MOTION FOR FINAL VOTE

4.7.2. START DISCUSSION ABOUT TERMINOLOGY CONCERNING THE PRM PROGRAMMES AT DIFFERENT LEVELS

(Programme, plan, clinical path, project, prescription, national programme, PRM team programme, PRM patient programme,...)



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4.8. GLOBAL ROADMAP FOR IMPLEMENTATION OF ICF ACROSS EUROPE

4.8.1. DEVELOPMENT OF AN INTERNATIONAL CLASSIFICATION SYSTEM FOR SERVICE ORGANISATIONS FOR HEALTH-RELATED REHABILITATION (ICSO-R 2.0). (CARLOTTE KIEKENS)

4.8.2. CULTURAL ADAPTATION OF ICF (ENRIQUE VARELA, AYDAN ORAL)

4.8.3. FRAMEWORK FOR CQM IN REHAB IN EUROPE (UEMS COUNTRIES) (MESO LEVEL) (STEFANO NEGRINI)

4.8.4. DEMONSTRATION PROJECTS OF REHABILITATION PLAN DEVELOPMENT (MICRO LEVEL) (MAURO ZAMPOLINI)

4.9. PPC ACTION PLAN 2014-18: (GOALS AND STATE OF THE ART) WHERE WE ARE?

4.10. ANY OTHER ISSUE

5. CLINICAL AFFAIRS COMMITTEE: WORKSHOP AGENDA

UEMS PRM Clinical Affairs Committee (CAC).
Agenda proposal for Bratislava meeting
Written by Mark Delargy/Karel Moses, 10.7.2017
8th September 2017 - Friday workshop

5.1. INTRODUCTION – C.A.C. ACTION PLAN 2014-18 (M. DELARGY)

5.2. MINUTES FROM MUNICH (K. MOSES)



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5.3.PAST AND CURRENT PROJECTS OF CAC

- 5.3.1. ESPRM CAC QUALITY OF CARE SESSIONS IN VILNIUS MAY 2018
- 5.3.2. REVISION OF PATIENT'S RIGHTS AND RESPONSIBILITIES - UPDATES
- 5.3.3. QUALITY OF CARE
- 5.3.4. ACCREDITATION OF PRM PROGRAMS – GEORGES DE KORVIN – PROGRESS WITH LATVIAN AND SLOVENIAN SUBMISSIONS
- 5.3.5. GUIDELINES COLLECTION AND DISPLAY
- 5.3.6. PUBLICATIONS ON THE INTERNET AND EUROPEAN JOURNALS
- 5.3.7. ICF AND MEASUREMENT IN REHABILITATION

5.4.PATIENT'S RIGHTS (AND RESPONSIBILITIES)

- 5.4.1. PAPERS FOR APPROVAL
 - Patient's rights and physicians rights: update (Hermina Damjan/ Mark Delargy)

5.5.QUALITY MANAGEMENT IN REHABILITATION

- 5.5.1. IMPLEMENTING QUALITY MANAGEMENT IN REHABILITATION
(G. Stucki)
- 5.5.2. DEVELOPING CLINICAL ASSESSMENT SCHEDULE
(G. Stucki and M. Zampolini)
- 5.5.3. IMPLEMENTING THE REHABILITATION PLAN
(M. Zampolini)



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5.6. REVIEW OF THE GUIDELINE PREPARATION

5.6.1. RECOMMENDATIONS ON: BEST AVAILABLE GUIDELINES FROM PRE-EXISTING GUIDELINES FOR APPROVAL USING AGREE TOOL METHODOLOGY.

1. TBI (M.Delargy),
2. SCI (C.A.Rapidi),
3. TBI children (R.Nunez),
4. Low back pain (K. Hornáček),
5. Evaluation and prescription of assistive devices in mobility problems (K.Moses).

5.7. PROGRAMMES OF CARE

5.7.1. PRESENTATION/ACCREDITATION PROGRAMMES OF CARE.

- a) Slovenian programme of care on Baclofen Pump in Spasticity: Presenter: Klemen Grabljevec
- b) Latvian programme on LBP – Presenter: Ande Nulle

5.7.2. SUGGESTIONS FOR REVISION/UPDATING OF ACCREDITATION PROCEDURES

(G. de Korvin and M. Delargy)

- a) Progress with programme approval at the national level before programme is submitted for UEMS PRM accreditation
- b) Develop the link between the scientific committee of national congresses and the Clinical Affairs Committee to refine the application template. To determine the validation process required from a National Rehabilitation service prior to review of the programme by UEMS CAC. Programmes applying for a first CAC presentation must be nationally recognised programmes before submission for UEMS PRM accreditation. Initial validation by the national rehabilitation service will provide confirmation that the programme has recognition and status at a national level. Such programmes seeking UEMS PRM approval will therefore need to have a validated national profile.
- c) To further develop the UEMS CAC accreditation process and further simplify the Accreditation procedure. To develop the plan to split the application template into a **first part** devoted to a structured description of the programme without accompanying data. A **second section** supplying the proof of service activity with data/tables etc which would be completed on-line and would provide validated service activity statistics.

5.8. AMBULATORY REHABILITATION –

Update from Georges de Korvin



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SATURDAY 9TH SEPTEMBER 2017

6. UEMS PRM SECTION & BOARD GENERAL ASSEMBLY (PLENARY SESSION)

6.1. ATTENDANDS

PATERNOSTROSLUGA	Tatjana	Austria
WICKER	Anton	Austria
QUITTAN	Michael	Austria
KIEKENS	Carlotte	Belgium
LEJEUNE	Thierry	Belgium
DRAGIČEVIĆ-CVJETKOVIĆ	Dragana	Bosnia & Herz. ESPRM
STEFANOVSKI	Gordana	Bosnia & Herzegovina
ILIEVA	Elena	Bulgaria
MOSLAVAC	SASA	Croatia
CHRISTODOULOU	NICOLAS	Cyprus
MOSES	Karel	Czech Republic
MARTINA	Kövári	Czech Republic
ANGEROVÁ	Yvona	Czech Republic
VOTAVA	Jiri	Czech Republic
HANSEN	Birgitte	Denmark
STÅHL	Minna	Finland
BOYER	Francois Constant	France
DELARQUE	Alain	France
WINKELMANN	Andreas	Germany
BAROTSIS	Nikolaos	Greece
MICHAIL	Xanthi	Greece
RAPIDI	Christina-Anastasia (Annie)	Greece
MICHAIL	Xanthi	Greece
FAZEKAS	Gabor	Hungary
CERAVOLO	Maria Gabriella	Italy
GIUSTINI	Alessandro	Italy - Expert
NEGRINI	Stefano	Italy
ZAMPOLINI	Mauro	Italy
FOTI	Calogero	ESPRM Delegate
NULLE	Anda	Latvia
HAZNERE	Ilze	Latvia
JUOCEVICIUS	Alvydas	Lithuania
LECHES	Marguerite	Luxembourg
ZAMMIT	Stephen	Malta
KUJAWA	Jolanta	Poland
TEDERKO	Piotr	Poland



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CANTISTA	António Pedro	Portugal
NUNES	Renato	Portugal
POPA	Daiana	Romania
ALESHIN	Gennady	Russia
KHASSANOVA	Dina	Russia
LAZOVIC	Milica	Serbia
PETROVIC NARKOVIC	Ivana	Serbia
PETER	Takac	Slovakia
HORNÁČEK	Karol	Slovakia
BURGER	Helena	Slovenia
VARELA	Enrique	Spain
STUCKI	Gerold	Switzerland - Expert
FRISCHKNECHT	Rolf	Switzerland
JANSSEN	Wim	The Netherlands
STAM	Henk	The Netherlands
WEVER	Daniel	The Netherlands
DINCER	Fitnat	Turkey
ORAL	Aydan	Turkey
KUCUKDEVECI	Ayse A.	Turkey
GOLYK	Volodymyr	Ukraine
VLADYMYROV	Oleksandr	Ukraine
SINGH	Rajiv	United Kingdom
BURN	John	United Kingdom

6.2. PRESIDENT'S REPORT (N. CHRISTODOULOU)

Dear members of the organizing committee from Slovakia, especially Karol Hornacek and Peter Takac, dear Treasurer of the UEMS Dr. Bernard Maillet, dear Vice President of the European Disability Forum (EDF) Mr. Patrick Clarke, dear delegates and senators of the PRM Section from all over Europe,

I would like to welcome all of you to Bratislava for the 14th General Assembly of my presidency and to thank all the Slovak delegates for hosting this General Assembly, in the beautiful and historic capital of Slovakia. On behalf of all the delegates, I would like to give our sincere thanks to the hosts for their warm hospitality and the excellent organization of this meeting.

We are happy today having with us the representative of the Executive Committee of UEMS treasurer Dr. Bernard Maillet, who will report us for the activities of UEMS on international level. Also, we are very happy because for first time we have managed to have with us a representative from the European Disability Forum: The Vice President Mr. Patrick Clarke, who will present us the work of the EDF concerning the disabled people in Europe. Since our specialty is the most relevant with the activities of the EDF and the motto of this organization is “nothing concerning us without us”, it is a great opportunity to set up a common action plan in a spirit of mutual understanding for coordination of our efforts in Europe towards a higher standard of Rehabilitation services in our continent.



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Dear colleagues, as in every meeting, it is my duty to let you know about the activities of the members of the Section Executive Committee following the last meeting in Munich.

Relations with UEMS Ex. Com. and Council:

Of course, Dr. Bernard Maillet will give you the general plan of the UEMS actions. I will focus only on subjects of common interest. The last UEMS Council meeting was organized in Tel Aviv in April 2017. Before that meeting we had prepared and sent to the Executive Committee of UEMS an enlarged questionnaire concerning a survey for practicing medicine by non-medical persons. We hope it will be used by UEMS for finding out the length of these inappropriate and illegal activities in Europe. Things that are useful to be mentioned in our Assembly are the following:

The 'Domus Medica Europea' is fully functioning with surplus. Due to the EACCME activities there was an increased income for UEMS of about >13%. A new process for the electronic accreditation of learning educational events (LEEs) has been established by EACCME and all persons responsible for this accreditation must learn and follow the new process. The committee for the European Training Requirements (ETR) of each specialty has circulated guidelines and template helping the Sections and Boards to prepare their own. We have found them very useful in preparing the ETR of our specialty, which will be voted later. CESMA celebrates this year the 10 years anniversary and thus its meeting was planned for Glasgow as it was the first one with the known Glasgow declaration. UEMS in 2018 will celebrate its 60 years anniversary and there is an open invitation to all of us for a future strategic Agenda. Some new rules of procedure have been validated in Tel Aviv concerning the more active involvement of Sections in the decision-making process. Also, an initiative has started for closer cooperation of UEMS with the European Societies of the several specialties. The first meeting will take place a day prior the Council meeting. The new UEMS Council will take place in Brussels from 19 to 21 of October 2017.

Relations with European national PRM societies and other European Bodies:

A. White Book revision:

Following the whole day constructive meeting in Munich, dedicated to the presentation of the several chapters of the WB and the discussions about the comments or questions received, the work of the Editorial Board continued in finalizing each chapter and there was a meeting in Ghent as well. I am happy that this work, which reflects the expectations of all the European PRM Bodies, has reached its final stage. Later today we are going to vote for this new edition and the planning for publishing will start. The aim is to launch the new WB during the European PRM congress in Vilnius on May 2018. This new edition of the White Book of PRM in Europe will be a very useful tool for the specialty and the PRM physicians in their relations with other disciplines and Organizations for Disabled Persons or in negotiations with their national governments and national health systems authorities.

B. Next Congresses in Europe:

I would like to mention that during this year we are going to have the Mediterranean PRM congress in Malta and the North-Baltic PRM Congress in Maastricht both in November. For 2018, we have been asked by the congress presidents of the European Congress in Vilnius Pr. Alvydas Juocevicius and Pr. Alain Delarque, to be co-organizers for scientific purposes together with all the European PRM Bodies and we have accepted this invitation. Also, the world congress of ISPRM will be organized next year in Paris and we have been invited to contribute by presentations to the scientific program by the French colleagues of the organizing committee. Also, I have exchanged letters of



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intentions with the ISPRM president Pr. Jorge Lains for a closer cooperation between ISPRM and the European PRM Bodies. I expect positive results before or during the world congress in Paris.

C. Process for transforming the Rehabilitation services in Ukraine:

The 3rd PRM seminar was organized in June 2017 in Kiev. During that seminar lectures were presented for all the fields of PRM that had not been covered in the first two seminars. Our Ukrainian colleagues, having now their national PRM society and having recognized the specialty of PRM in their country, they proceed to the necessary next steps for establishing the specialty in Ukraine.

Activity of our Executive Committee:

Since our last General Assembly in Prague we have been active in and out of the Section. The members of the Executive Committee were in close electronic co-operation in order to prepare the vote report and final minutes of the last General Assembly in Munich, discuss financial issues and other current issues and prepare the agenda of the General Assembly in Bratislava. Also, an intensive coordination for writing the EBPPs and follow the Delphi Rounds was going on all this period. The aim is to publish them separately and then publish till next summer, the part 2 of the e-book for the Field of Competence of PRM physicians. Another work having to do with the Board is the process for writing the e-book of PRM for the undergraduates, in an effort to harmonise the teaching of PRM to all Medical Schools in Europe. This book must be ready till next summer as well.

Many more things have to be done during the following years for developing our specialty, according to our Action Plan. The following reports of the Board, the Professional Practice Committee and the Clinical Affairs Committee will enlighten us for the systematic work that is done in each Body.

I wish all your plans and actions for the benefit and development of our specialty to be successful both for us and for the coming generations of PRM physicians. Thank you.

6.3.UEMS TREASURER'S REPORT (BERNARD MAILLET)

U. E. M. S. is Union Européenne des Médecins Spécialistes - European Union of Medical Specialists. It is an umbrella organization of National Associations of Medical Specialists located in Brussels. PRM is not mentioned as such in the Annex V of the Directive 2005/36/EC but as Physiotherapy. It is recognized in 23 of the 27 Member States according to Annex V. The minimal length for training mentioned is 3 years.

6.3.1. THE MAIN ADOPTION OF KEY DOCUMENTS IS:

- Guidelines on Malpractice and Medical Liability
- Statement on the Isernia Meeting on Ethics
- Declaration on “Commerce and Medical Practice”
- Information on “surgical implantation of long-term mechanical circulatory support”
- European Training Requirements for Medical Specialties
 - *Trauma Surgery*
- Creation of a Section in Pharmacology
- Creation of an MJC in Breast Care
- Financial problems related to the renovation of the UEMS House



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- Official move of the Address of the UEMS to the “Rue de l’ Industrie 24”
- Warming Up Reception on Friday evening

6.3.2. ON GOING DISCUSSIONS

- UEMS Sections and Boards
- Long discussions and clarifications about the financial “problems” of the UEMS
- The UEMS has a lot of resources
- The problem lies in the Cash Flow
- Critical issues have been avoided and solutions have been found

6.3.3. UEMS FINANCES

- Large Assets (about 8 Mo €).
- Domus Medica Europea values about 4 Mo € today (2 Mo when we bought it)
- Accounts of the UEMS Sections in Brussels
- Straight Loan has been paid back end of January
- Internal Fund amounts 616.140,00 - €
- This internal Fund has helped to solve the cash flow problem

6.3.4. OTHER OF KEY DOCUMENTS ARE:

- Proposal to have a Database for successful candidates examinations & Honorary Diplomas
- Update on the Revision of the EU Directive on Professional Qualification Recognition
- European Training Requirements for Medical Specialties
- Request from the Section of ORL to change the name into “ORL and Head and Neck Surgery”
 - Opposition of some Sections for instance Oral and Maxillofacial Surgery
 - Based on the Rules of Procedure, the names of the Sections should be the same as the name mentioned in Annex 5 of the EU Directive on PQR

It is only a recommendation but the UEMS Executive stresses that this has to be in accordance with the Annex as this is an objective reference

Request from the Section of Genetics to change the name into “Genetics and Genomics”

Adoption of some ETR’s

- Plastic Surgery
- Pediatrics
- Neurosurgery
- Manual Therapy
- Breast Surgery
- Angiology

6.3.5. ELECTIONS OF UEMS EXECUTIVE

President : Romuald Krajewski



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Secretary-General : Vasillios Papalois
Treasurer : Bernard Maillet
Liaison Officer : Zlatko Fras
Vice Presidents: Joao Grenho , Hans Helmqvist, Othmar Haas, Marc Hermans

6.3.6. EUROPEAN TRAINING REQUIREMENTS FOR MEDICAL SPECIALTIES

- Plastic Surgery
- Trauma Surgery
- Angiology
- Breast Surgery
- Manual Medicine
- Orthopedics

6.3.7. OTHER KEY DOCUMENTS

- Creation of an MJC in Rare and Undiagnosed Diseases
- Request from the Section of Genetics to change the name of the Section into “UEMS Section of Genetics and Genomics”.
 - *Similarly, to ENT this was rejected*
 - *It was proposed to lobby to the EU Commission to have changes of names such as for instance change the name of the Section of Physical Medicine and Rehabilitation as the Annex V mentions wrongly Physiotherapy*

6.3.8. DUE TO THE TERRORISTIC ATTACKS

The meeting of April 2016 in Brussels was cancelled

- Agenda will be discussed at the next Council meeting
- Decision to move the Tel Aviv Meeting to April 2017
- Approval of the Financial Situation of the UEMS for 2015 had to be given
- The Executive decided to have an e-mail procedure in order to approve it

6.3.9. DISCUSSIONS

- UEMS Sections and Boards
- Meeting of the 3 Groupings
4 topics for discussion:
 - Future Structure of the UEMS
 - EACCME
 - Reviewing Committees for ETR
 - Plenary Meeting of the Sections



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6.3.10. ADOPTION OF KEY DOCUMENTS

- Future Structure of the UEMS
- EACCME 2.0
- Terms of Reference for the European Training Requirements Reviewing Committee
- **ETR Reviewing Committee**

6.3.11. MEMBERSHIP

- Admission of the Bulgarian Medical Association as Full Member
- Admission of the Serbian Medical Chamber as Associate Member
- Admission of the Arab Board of Specialties of Iraq as Observer Member
- Change in the Member Organization representing Germany: SpiFa will replace GFB

6.3.12. SPECIALIST ISSUES

- Adoption of ETR's
Internal Medicine: approved
Neurology: approved
Pain Medicine: rejected
Laboratory Medicine: approved
- CTF
- Practice of some parts of Medicine by non-medical professions: presented by the PRM Section president Nicolas Christodoulou
- Statement on the ban of formalin

6.3.13. WORKING GROUPS

- e-Health
- CME – CPD
- Post Graduate Training
 - Quality of Patient Care and Specialist Practice in Current Health Care systems

6.3.14. CHANGES IN THE RULES OF PROCEDURES OF THE UEMS

Adoption by the UEMS Board of the Financial Report for 2016

Working Groups:

- E-Health
- Post Graduate Training
- CME-CPD
- Quality of Health Care



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6.3.15. EUROPEAN TRAINING REQUIREMENTS FOR MEDICAL SPECIALTIES

- Nuclear Medicine
- Psychiatry
- Genetics

Problem about the reference to a specialty of Genetics and Genomics... amended version with whenever the specialty is meant it would refer to Genetic so only while it is about the technique it can remain

- Gastro-Enterology

6.3.16. CHANGES IN THE RULES OF PROCEDURES OF THE UEMS

CONSTITUTIONAL ISSUES

- Creation of an MJC in Head and Neck Surgery
- Creation of an MJC in Thoracic Oncology
- Creation of a Division of Reproductive Medicine
- Creation of a Division of Clinical Embryology
- Proposal of change of name of the Section of Pharmacology into Clinical Pharmacology

6.3.17. NEXT UEMS MEETINGS

- October 19th 2017: Meeting with the European Scientific Societies - Brussels
- October 20th–21st 2017: Brussels
- January 2018: Advisory Council for EACCME Brussels
- April 13th–14th 2018: Marrakesh (Morocco)
- October 19th-20th 2018: Brussels

6.4. EUROPEAN DISABILITY FORUM (PATRICK CLARKE)

6.4.1. EDF'S SECRETARIAT IN BRUSSELS

10 staff members focusing on:

- Human Rights
- Accessibility
- New Technologies & Innovation
- Built Environment
- Transport
- Political Participation
- Employment & Social Services



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- Communications
- Membership

6.4.2. WHAT DO WE DO?

- Advocacy towards the EU, the Council of Europe, and the UN to fully implement the **UN Convention on the Rights of Persons with Disabilities (UN CRPD)** & related areas
- Member of the EU's **Independent Monitoring Framework** for the UN CRPD
- Involvement in **projects** which bring added value in progressing the UN CRPD in the European region
- Secretariat of the **Disability Intergroup** of the European Parliament

6.4.3. GOVERNANCE

- Annual General Assembly
- Board elected every 4 years
- Executive committee elected by the Board every 4 years
- Committees of the Board: UN CRPD – Women – Youth- Human rights and Non-Discrimination- Social Policy and Inclusion
- Advisory group to the Board on independent living and community-based services

6.4.4. WORK STRUCTURES

Email expert groups in:

- Built environment
- Transport
- Information & communication technologies,
- Sustainable development goals and international cooperation
- Structural funds
- Standardization
- Council of Europe

6.4.5. CURRENT PRIORITIES

- European Accessibility Act- now in Council and at the European Parliament
- Transport and Mobility
- New Technologies- successful adoption in 2016 of the Directive on Accessibility of Public websites
- Working on Audio visual media services, e communication, Marrakesh Treaty
- Political Participation
- EU social policies



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6.4.6. EUROPEAN PARLIAMENT

- Resolution on CRPD
- EDF observer at the CRPD Network
- Disability intergroup- EDF is secretariat
 - 2016: 2nd EDF meeting with Presidents of Parliament's political Groups
 - 4th European Parliament of Persons with disabilities, December 6th 2017.

6.4.7. STRUCTURAL FUNDS

- Training members, advocacy on the current and upcoming Cohesion policy
 - Human rights and CRPD
- Supporting our members in National reviews at the committee in Geneva
- Promoting and monitoring the CRPD at the EU level

6.4.8. YOUTH

Involved in a range of youth events

- European Youth Event
20-21 May 2016 | Strasbourg

6.4.9. WOMEN'S COMMITTEE

- [EU Disability Forum @MyEDF Jun 6](#) Congratulations to EDF's [@PirkkoMahlamaki](#) who was elected Board member of the European Womens' Lobby! [@EuropeanWomen #disability #women](#)

6.4.10. INTERNATIONAL

- Pilot exchange with regional DPOs
- Conference of states parties-successful events
- New resources to increase work on SDGs

6.5. APPROVAL OF THE MUNICH MEETING MINUTES

Approved unanimously

6.6. PRESENTATION OF NEW DELEGATES

New Delegate from Czech Rep. Martina Kovari

6.7. GENERAL SECRETARY'S REPORT (M. ZAMPOLINI)

Dear Delegates, Dear President,



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first at all I would like to thank:

- Karol Hornáček and Peter Takac to organize this meeting in a perfect way and to cooperate to the preparation of the meeting during the last few months.
- Bernard Maillet (UEMS), we are honoured to have a high representative of the UEMS, we put the cooperation with the UEMS as a first level of our activities
- Patrick Clarke, vice president of European Disability Forum
- Jiri Votava

6.7.1. THE ACTIVITIES OF THE LAST SIX MONTHS

- Organization of Bratislava Meeting;
- Lots of contacts with the delegates and PRM doctors;
- Keeping contacts with the UEMS;
- Support for survey and position papers;
- Harmonization of PRM activities (Ukraine)
- Last Seminar in June (Kiev)
- Work on White Book
- Meeting in Leuven (Belgium) for reviewing the new edition of white book (Editors meeting)
- Clinical Quality Management in Rehabilitation
- Meeting in Milan (Italy)
- Involvement of the delegates in the activities

Promotion of Board examinations and certification by equivalence

- Promotion of accreditation of program
- Working groups
- Guidelines
- CQM-R
- Call for the editorial board of Website and communication system

6.7.2. GOING TOWARDS KIEV MEETING

- Project of Clinical Quality Management in rehabilitation
- Populate guidelines from SISC of ESPRM and from authors of position papers of PPC
- We are preparing some survey to support our activity
- Working to finalise the White Book
- Each delegate is committed to update his individual data directly in the website (euro-prm.org).

See all of you in Kiev.

6.8. TREASURER'S BRIEF REPORT (W. JANSSEN)

Accounting rules UEMS changed 2013



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- general implemented all Sections
- Belgian Account to be used
- Belgian Tax Rules (as mentioned in UEMS fees letter)

CHANGES

- ACCOUNTING USING PNB ACCOUNT
- for all activities

6.8.1. CREATION UEMS INTERNAL FUND

CME funds 2014/2015/ 2016

Brussels, 15th February 2016

To the UEMS SECTION OF PHYSICAL & REHAB MEDICINE
To Pr N. Christodoulou

Dear Pr N. Christodoulou,

We thank you for your contribution to the UEMS Internal Fund.

Our records show that the UEMS SECTION OF PHYSICAL & REHAB MEDICINE has contributed to the Internal Fund

2100 EUR on the date of 7/1/2014
700 EUR on the date of 1/1/2015
2500 EUR on the date of 7/1/2015
1000 EUR on the date of 1/1/2016

enhanced by a bonus of 102.37€ on the date of 01/01/2016

and placed in the UEMS Internal Fund bank account :

6.8.2. ACCOUNT UEMS PRM SECTION PRM



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Date	31-12-2015	31-12-2016	06-09-2017
Bankaccount			
UEMS PRM SECTION PRM			
BNP PARISBAS UEMS PRM Section	5.834,10	17.405,88	24.383,08
UEMS INTERNAL FUNDS	4.300,00	4.300,00	378,00
	10.134,10	21.705,88	24.761,08

6.8.3. CREDITS 2016

- UEMS FEES
- FEE BOARD CERTIFICATION BY EXAMINATION
- FEE BOARD RECERTIFICATION
- FEE BOARD CERTIFICATION BY EQUIVALENCE
- FEE BOARD SITE CERTIFICATION VISITS
- FEE BOARD SITE CERTIFICATION
- INTEREST IN RELATION ACCOUNT
- ACCREDITATION OF CONGRESSES ETC (now in internal fund)

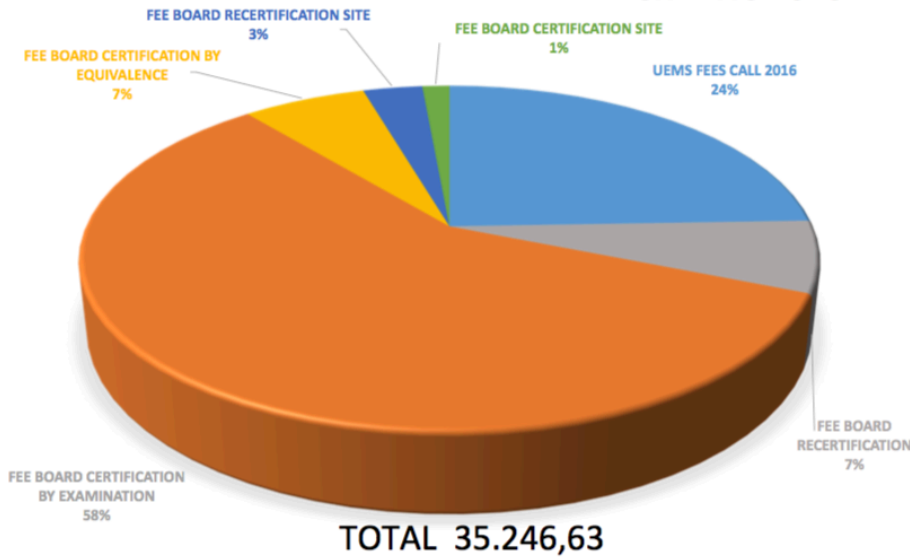


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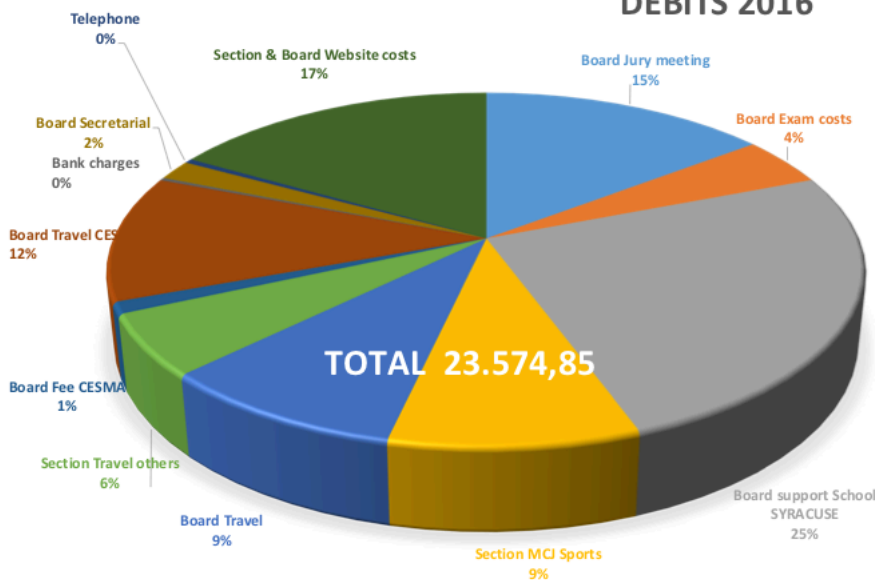


CREDITS 2016



6.8.4. DEBITS 2016

DEBITS 2016





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6.8.5. CREDITS BUDGET 2017

CREDITS BUDGET 2017

		sept 2017
• UEMS FEES	9.000	10.003
• FEE BOARD CERTIFICATION BY EXAMINATION	16.000	4200
• FEE BOARD RECERTIFICATION	2.000	950
• FEE BOARD CERTIFICATION BY EQUIVALENCE	1.200	1069
• FEE BOARD SITE CERTIFICATION VISITS	2.000	500
• FEE BOARD SITE CERTIFICATION	2.000	250
• EACCME ACCREDITATION OF CONGRESSES ETC	5.850	3922

BUDGET for DEBITS 2017

		sept 2017
• Board Exam Costs	1000	
• Board Jury meeting	4500	3475
• Board support School SYRACUSE	6000	
• Telephone/ website hosting costs	4000	2215
• Bank Costs PNB	40	102
• CESMA fee	250	250
• Board Travel	2500	

		sept 2017
• CESMA Travelcosts	2.500	2153
• Board Secretarial	450	252
• Section MCJ Sports	2000	
• Section Travel others	1500	1974



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BUDGET for DEBITS 2018

	2017	2018
• Board Exam Costs	1000	1000
• Board Jury meeting	4500	4500
• Board support School SYRACUSE	6000	6000
• Telephone/ website hosting costs	4000	4000
• Bank Costs PNB	40	100
• CESMA fee	250	250
• Board Travel	2500	2500
• CESMA Travelcosts	2.500	2500
• Board Secretarial	450	450
• Section MCJ Sports	2000	2000
• Section Travel others	1500	1500
• Section support E-Book		8000

6.9. BOARD REPORT

6.9.1. MOTION 1: RULES OF CERTIFICATIONS

approved with 1 abstention

6.9.2. MOTION 2: EUROPEAN TRAINING REQUIREMENTS

approved with 1 abstention

6.9.3. MOTION 3: CRITERIA FOR ENDORSEMENT

Unanimously approved

28 Delegates and 1 expert participated in the workshop

Tatjana Paternostro-Sluga

AUSTRIA

Thierry Lejeune

BELGIUM



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Gordana Stefanovski	BOSNIA AND HERZEG.
Elena Ilieva	BULGARIA
Sasa Moslavac	CROATIA
Nicolas Christodoulou	CYPRUS
Yvona Angerova	CZECH REP.
Minna Stahl	FINLAND
Francois Boyer	FRANCE
Nelly Kakulia	GEORGIA
Andreas Winkelmann	GERMANY
Nikolaos Barotsis	HELLAS
Zoltan Denes	HUNGARY
Maria Gabriella Ceravolo	ITALY
Anita Vetra	LATVIA
Alvydas Juocevicius	LITHUANIA
Stephen Zammit	MALTA
Wim Janssen	NETHERLANDS
Piotr Tederko	POLAND
Dina Khasanova	RUSSIA
Gennady Aleshin	RUSSIA
Peter Takac	SLOVAK REP.
Helena Burger	SLOVENIA
Karin Rudling	SWEDEN
Rolf Frischknecht	SWITZERLAND
Fitnat Dincer	TURKEY
Aydan Oral	TURKEY
John P S Burn	UK
Oleksandr Vladymyrov	UKRAINE

1. **Presentation of new delegates:** Mina Stahl informed the Board that she replaces the national manager of Finland for this meeting and that the national manager of Finland will likely resign and a new delegate will soon be nominated by her country.
2. **Changes and validation of the updated agenda:** the agenda was presented and approved by the workshop participants.
3. **Board certification:**
 - 3.1. **Action plan 2014-2018:** The goals of the action plan 2014-2018 concerning the Board certification, the targets to be achieved and the actions taken so far were presented by MG Ceravolo. It was reported how special incentives were given to people applying for Board certifications during 2016, up to June 30th, 2017. There was an increase in the number of Board certifications by examination (plus 12% in the years for which the special offer was



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applied, as compared to the previous ones), certifications by equivalence and re-certifications of Fellows (plus 100%), certifications and re-certifications of training units (plus 150%).

- 3.2. **Next Board examination** will take place on the 25th November 2017. Deadline for applications is September 30, 2017. The national managers were informed on the new exam management system adopted this year which will allow a faster processing & release of results with detailed statistics. Instructions will be sent in time to national managers with the examination material.
- 3.3. **Board exam procedural changes:** survey will be sent to national managers to investigate the possibility for an online examination. The results will be presented and discussed at next assembly.
- 3.4. **25th Anniversary of the Board Examination:** on the occasion of the anniversary a special session will be held at ESPRM Congress in Vilnius. The executive committee proposed to offer a reduction of the examination fee for 2018. The treasurer reported that there has been a balance in the finances of the Board, between the number of certified people (that has increased) and the income from each certification (that has been reduced). The majority of delegates did not support the proposal for examination fee reduction. Alternative initiatives to promote participation into the Board Exam will be adopted.
- 3.5. **Certification of Training Centres, Trainers and Recertification of fellows:** The delegates discussed the status of Board certifications on national level and the problems they face. A survey will be sent to national managers in order to assess the status of certifications in each country (including fellowships, trainers and training centres) and the reasons for eventual low numbers of applications.
- 3.6. **A proposal for updating the rules for the certification by equivalence** was presented by Rolf Frischknecht. The proposal was discussed, and suggestions were unanimously accepted and integrated into the final version (Annex I). The Board workshop recommends the General Assembly to accept the following motion.

MOTION:

1. The updated rules for the certification by equivalence are accepted as reported in the Annex I
 2. The new rules apply from the day of their approval by the General Assembly.
4. **European Training Requirements in PRM:** the proposal of the executive was sent by email to the delegates before the workshop and discussed during the workshop. The text was amended according to the suggestions of the delegates. It was unanimously decided to be presented to the General Assembly for approval (annex II).

MOTION: The European Training Requirements are approved by the General Assembly of the UEMS PRM Section and Board as reported in the annex II.

5. **Presentation of the EARM book “Dilemmas in PRM – the dilemma game”** was done by Henk Stam. A workshop will be organized at the Vilnius ESPRM congress to present the book. The scientific support of the Board was requested, and Board delegates are encouraged to send “dilemmas” to be included in the book. The book will be distributed for free.
6. **The project for Cochrane Rehabilitation e-book** was presented by Stefano Negrini. The project will last 2 years and will be financially supported by UEMS PRM Section, the PRM College, the ESPRM and EARM. Board delegates were unanimously in favour of the project.



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7. **Endorsement of Educational Events by the UEMS PRM Board Executive Committee:** the proposal of the executive committee for a set of criteria for the endorsement of scientific events was presented to Board Delegates, discussed and refined. The following rules were unanimously accepted by the workshop participants and are recommended to the General Assembly for approval:

ENDORSEMENT OF EDUCATIONAL EVENTS BY THE UEMS PRM BOARD EXECUTIVE COMMITTEE

Mandatory requirements

The event will be realized under the auspices of the Board provided that:

1. The goals of the meeting clearly state the relevance of the educational event to the field of PRM
2. The event is mainly dedicated to PRM physicians and PRM trainees;
3. The official language is English
4. Special discounts on the registration fee are offered to Board registered PRM trainees and Board Fellows
5. The event has been recognized as a CME / CPD event by the relevant national authority of the country where the event takes place or by EACCME
6. The duration of the event is of at least 8 hours (one day)
7. The request for Board auspices has been sent at least 2 months before the event, joint to the program in its almost final version
8. No financial support is asked to the Board
9. The scientific programme is organized independently and without input from commercial entities
10. Speakers and organizers will be required to declare any conflict of interest with commercial entities

Recommended (not mandatory) requirements

1. One of the main organizers of the event is a Board Fellow
2. The Faculty is international (including a minimum 2 speakers coming from a different country than the one hosting the event)
3. The results of the customer satisfaction questionnaires filled in by the participants will be made available to the Board, after the event conclusion

MOTION: The criteria for the Endorsement of Educational Events by the UEMS PRM Board Executive Committee are accepted.

8. Educational Activities of the Board:

8.1. The e-book for the undergraduates (editors F. Franchignoni, N. Christodoulou, MG Ceravolo): it was reported that the chapters were submitted by the authors and are under review by the editorial board. The authors will receive editor's feedback by mid October and will be requested to provide their revised version by the end of November.

8.2. Sonographic Atlas for Common MSK Pathologies: the e-book which will be published under the auspices of the Board will be available online by the end of 2017. Free codes to access the electronic version will be offered by the Board on the occasion of the ESPRM & ISPRM congresses.

8.3. Educational Resources in PRM (editor F Franchignoni): a collection of selected free access resources was prepared by Prof F. Franchignoni. It is published on the website of the Board (free access). National managers are kindly requested to inform trainees and Fellows about this material but also to send links which will be included in the next revision. The concept is to maintain a constantly updated version online.



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- 8.4. Updates in PRM topics** (Board of editors: S. Munoz-Lasa, F. Dincer, N. Barotsis): the concept of project was presented by Prof. Fitnat Dincer. Four chapters are ready and published on the website of the Board. National Managers who wish to contribute can contact F. Dincer.
- 8.5. Online course on ESWT** (Coordinators: N Barotsis, E Ilieva): The e-learning course on ESWT will start in October 2017 and is estimated to be completed by the end of December 2017. Upon successful completion, a certificate of theoretical competency will be given. At the first course 2 trainees from each country will be accepted without registration fees. In case of vacant places, trainees from other countries or Board fellows from countries not presenting trainees will be accepted.
9. **Support of future educational events:** John Burn presented a proposal on the organization of a Spinal Rehabilitation Course in the UK and asked for the support of the Board. The course is estimated to be held in Spring 2019. Organizers are encouraged to apply for the Board financial support following the formal procedure.
10. **Report of the Coordinator of National Managers:** Prof. Fitnat Dincer presented her surveys related with: (1) The number of PRM specialists and the number of EBPRM certified PRM doctors in the European Countries. (2) The rotations of the PRM trainees, the departments attended during their training other than PRM departments, the duration of the rotation.

6.10. PPC REPORT

6.10.1. MOTION1: COLLABORATION WITH SPORTS MEDICINE

approved with 1 abstention

6.10.2. MOTION2: E-BOOK COCHRANE

Unanimously approved

6.10.3. MOTION 3: WHITE BOOK APPROVAL

approved with 1 abstention

Chairman: Enrique Varela Donoso (Spain)

Section Deputy Secretary to the PPC: Carlotte Kiekens (Belgium)

Participants:

- | | |
|--------------------------|----------------|
| 1. Michael Quittan | Austria |
| 2. Anton Wicker | Austria |
| 3. Elena Ilieva | Bulgaria |
| 4. Nicolas Christodoulou | Cyprus |
| 5. Martina Kovari | Czech Republic |
| 6. Jiri Votava | Czech Republic |



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7. Alain Delarque	France
8. Nikolas Roussos	Greece
9. Gabor Fazekas	Hungary
10. Stefano Negrini	Italy
11. Calogero Foti	Italy
12. Ilze Haznere	Latvia
13. Daan Wever	the Netherlands
14. Jolanta Kujawa	Poland
15. Filipe Antunes	Portugal
16. Catarina Aguiar Branco	Portugal
17. Klemen Grabljevec	Slovenia
18. Milica Lazovic	Serbia
19. Ivana Petronic Narkovic	Serbia
20. Gerold Stucki	Switzerland
21. Ayse Küçükdeveci	Turkey
22. Aydan Oral	Turkey
23. Volodymyr Golyk	Ukraine
24. Rajiv Singh	United Kingdom

Delegates attending for the White Book discussion:

Anni Rapidi (Greece)
Fitnat Dincer (Turkey)

Other attendants for the White Book discussion:

Pedro Cantista
Xanthi Michail

Invited: dr. Bernard Maillet, UEMS treasurer

6.11. ONGOING PAPERS:

13) Pain	Gabor Fazekas Preparing for Delphi round 3
14) TBI	Klemen Grabljevec Preparing for Delphi round 1
15) Stroke	Katharina Stibrant Sunnerhagen (Ayse Kucukdeveci) Writing recommendations for Delphi round 1 Discussion about when to mention a reference, it should be really with regard to the role of the PRM physician; for example, you can refer to some good guidelines and suggest the PRM physician to follow these.
16) SCI	Annie Rapidi Preparing for Delphi round 3



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- 17) Progressive and neurodegenerative disorders - Maria-Gabriella Ceravolo
Writing recommendations for Delphi round 1
Proposal to make three separate papers under the responsibility of Maria-Gabriella Ceravolo
1. Parkinson disease
 2. Multiple Sclerosis
 3. Dementia
- 18) Neuromuscular Disease Rolf Frischknecht
New first author: Milica Lazovic
- 19) Cardiovascular disease Alvydas Juocevicius (Aydan Oral)
Delphi round 3 ongoing
- 20) Respiratory disease Aydan Oral (Alvydas Juocevicius)
Delphi round 3 ongoing
- 21) Oncological Ayse Kucukdeveci
Writing recommendations for Delphi round 1
- 22) Limb loss Carlotte Kiekens
New first author: Helena Burger
Writing recommendations for Delphi round 1
- 23) Cerebral Palsy Karol Hornacek (presented by Jolanta Kujawa)
Systematic Review done, selection of papers on abstracts ongoing
Ivana Petronic Narkovic is added as a co-author
- 24) Pregnancy Carlotte Kiekens
Starting phase

6.12. FINISHED PAPERS IN THE COURSE OF PUBLISHING (VOTED IN MUNICH)

Ageing Aydan Oral
Accepted for publication

6.13. PUBLISHED PAPERS

Obesity Paolo Capodaglio
Methodology Stefano Negrini
Spinal deformities Stefano Negrini

6.14. PARTICIPATION TO MJCS

- a. Pain Medicine
 - o No news.
- b. Spine Surgery
 - o No news.



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c. Manual Medicine

- A meeting is planned in Brussels October 19th 2017 during the UEMS Council to prepare a curriculum with the ESSOMM (European scientific society of manual medicine), President is Dr. Hermann Locher.

d. Sports Medicine

- The last meeting took place in Limassol 23rd June 2017.
- The Section of Orthopaedics was represented for the first time
- A 6-12month training in PRM is required for Sports Medicine residents. The curriculum concerning PRM has been defined and we are kindly asked to provide it in PRM departments
- Recognition of Sports Medicine on EU level is ongoing
- Certification of fellows by examination is organised for the first time at the end of 2018.

MOTION 1

The UEMS Section of Physical and Rehabilitation Medicine (PRM) will give directions to all the PRM departments in Europe to teach Sports Medicine residents during their 6 or 12 months training in Physical and Rehabilitation Medicine, focusing on the following topics and not on the general PRM curriculum. In case this is not possible, they must not accept Sports Medicine residents for training.

SPORTS MEDICINE: 6-12 months training in Physical and Rehabilitation Medicine

Clinical anatomy:

Relevant regional anatomy, including normal variations and the relevance for injury risk, injury prevention and injury management.

Acute management of common musculoskeletal injuries.

General Pathology of the Musculoskeletal System:

Understanding common clinical signs & symptoms in general musculoskeletal pathology, which may present in athletes.

Understanding of the findings which may be detectable by imaging and other relevant investigations e.g. EMG, nerve conduction studies, diagnostic ultrasounds etc.

Techniques of aspiration or injection of joints and possible complications.

Acute and Overuse Injury Management:

The principles of managing acute soft tissue injury e.g. lacerations, sprains, strains, contusions, haematomas, joint injuries.



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The principles of assessing, investigating and managing overuse injury.

Principles of the conservative management of injury: Principles of injury rehabilitation for ligament, tendon, muscle, bone, joint. Multidisciplinary approach to rehabilitation. The use of taping, splints, braces, orthotics.

Musculoskeletal Radiology Knowledge of finding. Gait and Biomechanical Assessment Knowledge.

Sports for persons with disability.

approved with 1 abstention

6.15. EUROPEAN CONGRESS IN VILNIUS WITH AN OFFICIAL SESSION OF 240 MIN

Thursday: 2 sessions of 2 hours each

Presentation of published and ongoing EBPPs (min 2nd Delphi round by then) (up to 15 minutes each)

1. Introduction (Varela/Christodoulou)
2. Methodology (Negrini/Kiekens)
3. Spinal deformity (Negrini)
4. Obesity (Capodaglio)
5. Ageing (Oral)
6. Pain (Fazekas)
7. Cardiovascular (Juocevicius)
8. Respiratory (Oral)
9. Spinal cord injury (Rapidi)
10. TBI (Grabljevec)
11. Stroke (Stibrant Sunnerhagen)

6.16. ISPRM CONGRESS IN PARIS.

Anton Wicker (European ISPRM liaison) will talk with the President of the local organising committee in France Alain Yelnik and give us feedback by e-mail. Final decision can be approved in Kiev or if necessary earlier by e-mail.

6.17. PROMOTION OF PRM TO UKRAINE

Volodymyr Golyk gives a short update on the activities in Ukraine.
A law recognising the PRM specialty was published.



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The four seminars for harmonisation of rehabilitation services in Ukraine for a total period of 160 hours to senior colleagues which have been organised by UEMS PRM S & B finished last June.

A time table for implementing the training in PRM for younger colleagues was adopted by the local authorities.

Volodymyr Golyk invites us to the next UEMS PRM meeting in Kiev 23-24 March 2018.

6.18. FOUR SUPPLEMENTARY QUESTIONS ARE DISCUSSED AND APPROVED.

These questions will be sent out in a survey to all UEMS PRM delegates.
Presentation on the activities performed and planned.

6.19. COCHRANE REHABILITATION FIELD:

Presentation of an e-book project and request to support it from all European PRM bodies.
The estimated budget is 50 000 Euro spread over 2 years.

- The European Academy will give a symbolic financial support (1000 €/year = 2000 €)
- ESPRM has already decided to contribute up to 16 000 Euro
- The European college of PRM decided to contribute up to 16 000 Euro
- Proposal that the UEMS PRM Section contributes up to 16 000 Euro

MOTION 2

The UEMS PRM Section supports the development of a Cochrane Rehabilitation e-book project with up to 16 000 Euro, spread over 2 years.

Unanimously approved

3. WHITE BOOK: DISCUSSION ON CHAPTER 0 AND DICTIONARY AND PREPARE MOTION FOR FINAL VOTE

Portugal has a political problem considering that PTs are allowed to prescribe according to a law published last week. All paramedics can do diagnosis and treatment.

It is agreed for “working in a multiprofessional team in a collaborative way with other disciplines, under the leadership of a PRM physician”.

For Portugal it should be clearly stated that the PRM physician is the coordinator and has the lead. Of course, this is a problem of many countries and not only of Portugal.

When we refer to PRM physicians we can state their competence for clinical diagnosis and functional assessment. Therefore, avoid the expression of functional diagnosis.

It is advised not to use the term ‘preferred’ but be more affirmative.



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A statement in chapter 8 about monoprofessional therapy is very delicate. This statement about monoprofessional therapy in the long-term phase will be modified to include ‘under the supervision and prescription of a PRM physician’.

The terminology concerning “Persons with disability” or “Persons experiencing or likely to experience disability” should be taken into account and used properly at each case.

A suggestion was made concerning urinary incontinence in Chapter 7. The corrections will be done.

In Chapter 7 page 5 the word “responsibility” for the care for persons with disability is going to be changed into ‘take care’.

Chapter 0 is revised for ICF purposes in order to be consistent with the official terminology.

The White Book will be circulated after final changes before the vote in the European Academy (23/24 November).

MOTION 3

The UEMS PRM Section and Board adopts the final version of the third Edition of the White Book on PRM in Europe with the changes agreed during the PPC workshop of 8 September 2017.

approved with 1 abstention

6.20. START DISCUSSION ABOUT TERMINOLOGY CONCERNING THE PRM PROGRAMMES AT DIFFERENT LEVELS

A “PRM actions terminology” project is proposed.

6.20.1. A.AIM

To define the terms of the actions performed by PRM physicians at the different levels of care, so to better distinguish them

6.20.2. B.STEPS

1. Set-up of a Committee to work through web meetings



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2. Actions of the Committee (working through skype meetings)
 - a. Definition of a first list of possible terms
 - b. Search of relative definitions and synonyms
 - c. Definition of the reference scheme
 - d. Definition of the concepts for the actions
 - e. Identification of the appropriate terms
 - f. Definition of the terms
3. Kiev: presentation in the PPC and discussion – eventual motion for approval
4. Publication

Bernard Maillet proposes to present the consensus on the terminology at the UEMS Council in order to spread it among all physicians. Europe

6.20.3. DEVELOPMENT OF AN INTERNATIONAL CLASSIFICATION SYSTEM FOR SERVICE ORGANISATIONS FOR HEALTH-RELATED REHABILITATION (ICSO-R 2.0)

A new version ICSO-R 2.0 is under revision by some worldwide experts. It will also be sent to the PPC members for revision.

6.20.4. CULTURAL ADAPTATION OF THE CLINICAL ICF TOOL

This process is ongoing in different countries. There is no real deadline, the countries/language communities are autonomous on this. The process is finished in Italy and Poland.

6.20.5. FRAMEWORK FOR CLINICAL QUALITY MANAGEMENT (CQM) IN REHABILITATION IN EUROPE (UEMS COUNTRIES) (MESO-LEVEL)

Aim:

1. Identification and definition of Rehabilitation settings in a European perspective
 - a. A representative commission (min 2 countries per European area) will be established to make an overview and identification of significant settings
 - b. A consensus conference will be organised in Kiev (March 2018) on Wednesday before ESPRM/UEMS PRM Meeting. The results will be discussed in the Kiev PPC and a motion will be presented at the Kiev GA. Then a paper can be published.
2. Identification of the ICF instruments to be applied for CQM in each setting (default and optional)
 - a. ICF instruments will be defined in each country



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- b. A consensus meeting will be organised in Vilnius at ESPRM2018
- c. The results will be discussed in the Stockholm PPC (September 2018), a motion will be presented at the Stockholm GA. Then a paper can be published

6.20.6. DEMONSTRATION PROJECTS OF REHABILITATION PLAN DEVELOPMENT (MICRO-LEVEL)

This project will be dealt with in the Clinical Affairs Committee. Mauro Zampolini presents the project.

Bernard Maillet proposes to present the project at the UEMS Council in order to spread it among all physicians.

Call for the Editorial Board of the UEMS PRM Section & Board website: 2 candidates required.

6.21. REPORT OF CAC

Chair: Mark Delargy (Ireland)

Secretary: Karel Moses (Czechia)

Participants: Mauro Zampolini (Italy, ESPRM), Birgite Hansen (Denmark), Christina Anastasia Rapti (Greece), Alessandro Giustini (Italy), Foti Calogero (Italy), Anda Nulle (Latvia), Zaiga Kalnberza (Latvia), Marguerite Leches (Luxembourg), Henk Stam (Netherlands), Renato Nunes (Portugal), Daiana Popa (Romania), Karol Hornacel (Slovakia), Dragana Dragicevic Cvjetkovic (Serbia), Klemen Grabljevec (Slovenia), Gerold Stucki (Switzerland)

Total: 17

Munich CAC Minutes of March 2017 were agreed.

I. PAST AND CURRENT PROJECTS OF CAC

- ESPRM CAC Quality of care sessions in Vilnius, May 2018
- Revision of patient's rights and responsibilities
- Quality of care
- Accreditation of PRM programs
- Guidelines collection and display
- Publications on the internet and European journals
- ICF and measurement in rehabilitation

1. CAC Accreditation has been dependent on the applicant being UEMS Board certified.



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The committee considered this condition and decided that the CAC would accept accreditation applications from PRM specialists who have been verified by their country's UEMS delegate. This modification of the application criteria may help attract greater numbers of applicants for CAC accreditation.

The CAC acknowledged the limited number of applications for accreditation in recent years. The CAC noted that the accreditation process is necessary only if applications are made regularly. CAC determined that Accreditation only needs to continue if there is a reasonable a flow of applications. If over a period of two years ie by CAC meeting in September 2019 there are less than 2 applicants, the CAC will review the situation. The CAC will then review the issue and make a decision at the UEMS PRM CAC meeting about whether the CAC accreditation is no longer needed.

In the meantime, CAC will encourage further applications and steam line the process. 3 strategies to promote applications for accreditation will be pursued. Circulation of PDF paper/brochure on the benefits of accreditation, improve access to the web pages and deliver an education and promotion session at ESPRM 2018 congress.

2. CAC Session in the European Congress of PRM in Vilnius (May 2018):

- Comparison of PRM accreditation procedures to explore developing quality in PRM rehabilitation programmes of care
- Accredited programmes presentation chaired by M. Delargy with presentations by UEMS PRM specialists who have successfully engaged with CAC accreditation and can speak to the benefits of CAC accreditation.

3. Patient rights - MD presented the latest draft of Patient's rights paper which had been circulated by email to CAC delegates who attended the Munich CAC. CAC will circulate the latest version of the paper to all delegates of the Section and board inviting comments by email before preparing the final draft for the UEMS CAC in Kiev March 2018.

4. Clinical quality assessment using ICF

Gerold Stucki presented his progress in developing a functional profile for PRM patients. He spoke about clinical assessment management in rehabilitation.

- Nottwil recommendations
- ICF - Malaysian model description
- building a functional profile from verified tests (FIM, Barthel, SF-36, DRS, FAC, ADL-IADL)

Mauro Zampolini presented

- Rehabilitation 2030
- Action plan 2014 - 2018 - collaboration with WHO
- Functional profile
- defining rehabilitation plan using ICF - ICF Reader in Russia

Conclusion:

We need to move from a series of intervention to a personalised rehabilitation plan

- The assessment (also from the patient perspective)
- The goal definition (Shared)
- The team working
- The Patient Centred Outcome



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- The importance of the ICF as a shared language
- Propose at level of UEMS Council the concept of Functional Assessment as a Medical Competence and should be reported in medical reports in the continuity of care.

Motion (1):

- We approve to produce a document to specify the methodology for the **Individual Rehabilitation Plan** using the ICF Clinical Tools.

Motion (2):

We approve the following steps of the project:

- Definition of a working group
- Define a methodological document about:
 - Assessment methodology
 - Individual Rehabilitation Plan
- The document will be presented at Kiev meeting
- Start of a pilot project involving some European Rehabilitation Centers
- Intermediate report of the project in September 2018 Stockholm meeting
- Final report of the pilot study in Spring 2019

5. Presentation of programmes of care for accreditation

Latvia: on Rehabilitation after Low Back Surgery and Slovenia: on Spasticity - ITB programme of care.

Dr Zaiga Kalnberza presented- „In-patient PRM programme for patient after lumbar surgery with neurology deficits “. As reviewers appointed K. Moses and K. Hornáček. The CAC approved the Latvian PRM rehabilitation programme for accreditation subject to a final review by Dr Moses. The CAC recommend that the General assembly accept the Latvian programme for certification.

Dr Klemen Grabljevec - PRM Spasticity with ITB - baclofen pump - reviewers appointed - Profs Leches and Zampolini. The CAC commented Dr. Grabljevec on the Spasticity ITB programme

6. Guidelines collection and display

There are collectors for guidelines in some areas:

- TBI (M. Delargy)
- SCI (C.A. Rapidi)
- TBI children (R. Nunes)
- Low back pain (K. Hornacek)
- Evaluation and prescription of assistive devices in mobility problems (K Moses)
- Multiple sclerosis (M. Zampolini)
- Cerebral palsy (H. Stam) (new)

Until next meeting in Kiev:

C.A. Rapidi, B. Hansen and A. Nulle will evaluate the SCI guidelines via Agree tool
K Moses will filter rehabilitation guidelines which were prepared according to Agree tool.



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Proposal - ask the delegates for local guidelines and verification them via Agree tool. If yes, extract and translate the recommendations into English.

7. Others

As an addition K. Moses presented results of his team in development of hospital information system respecting raw data collection for statistical and economical evaluation to improve quality of care. (patient - functional and medical status evaluation in raw data - goals - service/ intervention - planning - internal standards - availability - professional personnel - competencies - time - place - status of application - results/ outcomes - expenses - price - payments – sustainability)

6.22. REPORT OF THE BALNEOLOGY PWG MEETING

PRESENCES

11 delegates from 7 countries:

Slovakia
Check Republic
Bosnia-Herzegovina
Romania
Georgia
Latvia
Portugal

1. REPORT FROM THE BALNEOLOGY GROUP COORDINATOR PEDRO CANTISTA

- ESPRM Congress 2016– Estoril
- ISMH- Romania – Bucharest - 2016
- FEMTEC – Armenia – Jermuk - October 2016
- Heviz – Hungary - November 2016
- Montpellier, France, March 2017
- MinWat – Luso – Portugal - May 2017
- ISMH – Moscow – June 2017

6.22.1. CONFERENCES

- Balneology on the UEMS
- Balneology as a part of the field of competence of PRM Specialists
- Balneology efficacy: literature evidence and clinical experience
- Balneology on pediatrics: literature review and our experience
- Medical Balneology Scientific Investigation: towards an European framework
- Relevance and strategic aims of a joint medical balneology scientific investigation in Europe
- Thermal Medicine: which ways to the future?



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6.22.2. ESPRM NEW SPECIAL INTEREST SCIENTIFIC COMMITTEE (SISC) ON BALNEOLOGY

- ESPRM collaboration
- Scientific database
- Research
- Congress activities
- Publication

6.22.3. TASKS OF THE BALNEOLOGY PERMANENT WORKING GROUP (PWG)

- Consensus between different countries regarding PRM and Balneology
- Balneology Competence in Europe
- The European Board Core curriculum on Balneology for PRM Specialists
- The new Pedagogic Balneology Unit in Vidago and its cooperation with our PWG

6.22.4. COOPERATIONS

Sociedade Científica

Sociedade Portuguesa de Hidrologia, Médica e Climatologia, 1952.

6.22.5. CONCLUSIONS

- This group will cooperate with the ESPRM SISC on Balneology in the preparation of the Vilnius Congress
- This group will work to know in detail the curricular contents in the different European Countries and try to build a project of common standard in what concerns PRM
- With this achievement, we intend to have PRM Specialists admitted on the European Board of Medical Hydrology
- To facilitate this goal, we will organize in collaboration with the ISMH international courses, starting a Summer School of Balneology.

6.23. WEB EDITORIAL BOARD

- Karel Moses
- Sasa Moslavac
- Rolf Frischknecht



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6.24. REPORT OF UKRAINIAN HARMONIZATION PROCESS

(v. Golyk)

6.24.1. UKRAINIAN PHYSICAL AND REHABILITATION MEDICINE (REHABILITATION SERVICE) DEVELOPMENT UPDATES 2015 - 2017

WHO 05.05.2001

54 сесія Асамблеї ВООЗ
(резолуція WHA 54.21)

Qualification characteristics (list of competences)

Physical and Rehabilitation Medicine physician

Physical Therapist*

Ergotherapist*

*versions to be re-edited

Order to Ministry of Health Order: Nov 17, 2016 #1171

Implementation in Ukraine

International classification of functioning, disabilities and health

(Acting Minister of Health Special Directive 15.12.2017 №183)

Participants: Ministry of Health, Ministry of Social Policy, Ministry of Education and Science

Tool: WG for Inter-Ministerial Coordination

MEMORANDUM WITH UEMS-PRM

Possibility of collaboration:

Exchange of information and experiences;

Collaboration in the field of development and approval of curricula by UEMS PRM S&B for initial training, continuous medical education and continuous professional development for Physical and Rehabilitation Medicine physicians;

Collaboration in area of improving quality of rehabilitation care;

Collaboration in area of Professional Practice of Physical and rehabilitation Medicine;

Joint research projects;

Other forms acceptable to the Parties within the frames of Ukrainian legislation

EDUCATIONAL ASPECTS FOR REHABILITATION PROFESSIONALS

(UA Cabinet of Ministers Decree: Feb 02, 2017 №53)

PRM physicians:



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Area of knowledge: 22 Health care
Specialty: 222 Medicine (postgraduate level)

Physical therapy

Ergo therapy

Area of knowledge: 22 Health care

Specialty: 227 Physical therapy, ergotherapy (Bachelor/Master graduate level)

72+80 hours

Sep – Nov 2016+

Feb – Jun 2017

16 academicians

ACTION PLAN

MD of Physiotherapy

MD of Treatment Gymnastics

MD of Treatment Gymnastics and Sports medicine

TO

MD of Physical and Rehabilitation Medicine

Types of curricula:

*MD of Physiotherapy – MD PRM (3,5 months+)

*MD of Treatment Gymnastics – MD PRM (3,5 months+)

*MD (involved into rehab service) – MD PRM (3,5 months+)

**MD – MD PRM (4 years)

Currently in Ukraine:

MDs of Physiotherapy - 2015 - 2016: 984 - 1060 pers.

MDs of Treatment Gymnastics and Sports Medicine –

2016: 452 pers

PRIORITY: RETRAINING THOSE, WHO MUST BE RECERTIFIED IN 2018

Stop initial training of MDs of Physiotherapy / MDs of Treatment Gymnastics since Jan 2018

Changes to MoH Order #385 Feb, 28 2002

(MoH approved June 15, 2017)

«LIST of MD position name» Section III «Physicians» - position 139 - PRM Physician



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ADD «LIST of positions of functional specialists with Higher NONmedical education in Health Care Facilities»

Physical therapist

Ergotherapist

Social worker

Psychologist

EDU LEGISLATION:

Changes to MoH Order #359 Dec 12, 1997 (Nomenclature of Physicians specialities)

Changes to MoH Order #346 Dec 12, 1998 (List of specializations (secondary) and CPD for Physicians and Pharmacists)

Changes to MoH Order #81 Feb 23, 2005 (List of names and duration of specializations (primary - internship) for Physicians and Pharmacists)

Working group ... for InterMinisterial coordination ...
(MoH Order April 14, 2017 №441)

Representatives (25 persons):

UA President and UA Government Ombudsmen (3)

UA Parliament Deputy (1)

Ministry of Public Health (6)

Ministry of Social Policy (3)

Ministry of Education and Science (1)

Military Ministries (Defense, National Guard, Intern Affairs) (5)

National Academy of Medical Sciences (2)

NGOs (professional, people with disabilities) (4)

Plan for implementation ICF in Ukraine

(UA Cabinet of Ministers Directive - developing)

ICF TRANSLATION TO UA

WHO trainings

Course 1: Implementing ICF in Ukraine: changing rehabilitation paradigm (2.5 days), FOR: professionals, administrators, stakeholders – lecture format

Course 2: Assessing and reporting disability in Ukraine: from ICIHD to ICF, from diseases to activities and participation (2.5 days), FOR: Health professionals, members of MSECS – seminar format (20)

Including ICF blocks in curricula (PRM, PT, OT, GPs, undergraduate medical students)

Introduction rehabilitation service routine / rehab statistics

Changing legislation on Medical and Social Examination service



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Change №6 (National Classificatory of occupations)
Nurse of Treatment Gymnastics / massage - delete
Physical Therapist Assistant – added
Instructor of Labor Adaptation / Therapy – deleted
Ergotherapist Assistant – added
MD Therapist – MD of Internal Medicine

“Handicapped” newborn “Law for invalidity prophylaxis and system of rehabilitation in Ukraine”
(registered in UA Parliament #4458 April 15, 2016)

Returned for corrections back to author group (March 22, 2017)!!
New “Law for the rehabilitation system”
entered Parliamentary Committee for veterans and invalids March 28, 2017
Processing is ongoing

MEMORANDUM OF COLLABORATION WITH WORLD FEDERATION OF OCCUPATIONAL THERAPISTS

Exchange of information and experiences; including facilitation of communication and interaction with key stakeholders involved in progressing the development of Occupational Therapy in Ukraine (including but not limited to Ministry of Health, appropriate NGOs, government institutions, medical and health care bodies);
Exchange of delegations and health care specialists;
Organization of occupational therapy education programs;
Collaboration in Twinning, other EU and other international joint programs;
Joint research projects;
Other forms acceptable to the Parties.
Joint development and management of proposals for Occupational Therapy capacity building

Steps:

Changes to MoH Order #195 Dec 25, 1992
prerequisites for PT Assistant
prerequisites for OT assistants
prerequisites for PT
Prerequisite for OT

Steps:

Changes to MoH Order #195 Dec 25, 1992
prerequisites for PT Assistant
all persons already practiced (“nurses of treatment gymnastics”, “nurses of massage”, “physical rehabilitologists”) + BSc “Physical rehabilitation” (any), MSc (distance learning)

Changes to MoH Order #195 Dec 25, 1992



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prerequisites for OT Assistant

all persons already practiced (“instructors for labor therapy”, “instructors for labor adaptation”) + ALL “Ergo” curricula NOT approved by WFOT

Changes to MoH Order #195 Dec 25, 1992

prerequisites for PT

MSc (stationary curriculum)

Changes to MoH Order #195 Dec 25, 1992

prerequisites for OT

MSc (curriculum, approved by WFOT)

Professional regulations....

Functional specialists

Development and harmonization of mechanisms of professional regulations (PTs, ErgoTs): certification / recertification / licensing of professional activities according to WCPT/WFOT requirements and regulatory principles of EU countries with the same historical experience

OUR ACTUAL GOAL

Educational / promo activities for health care professionals:

REHABILITATION is...

Finalizing PRM initial training / retraining curricula and started running curricula since Jan 2018

Selecting MDs for retraining to PRM MDs in health care facilities

Involving (engaging) graduates from NONmedical curricula to health care facilities: clinical training – selection – potential employment

Creating and developing local multidisciplinary teams

Engagement of rehab professionals on improving English speaking abilities!!!!

6.15: NEXT CONGRESSES

Mediterranean Forum of PRM Congress: 9-12 November 2017 – Malta

European Society Congress of PRM: 2-5 May 2017 – Vilnius

ISPRM Congress: 8-12 July 2017 – Paris

6.16: WORKING DIARY:

Board examinations: 25/11/2017

Board Executive Committee meeting: 15/12/2017.



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6.17: NEXT GENERAL ASSEMBLIES:

- Kiev (Ukraine) 23-24 March 2018
- Stockholm (Sweden) 7-8 September 2018
- Budapest March 2019

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ANNEX I

Certification of PRM Doctors by Equivalence for senior PRM doctors trained or specialised in UEMS full member countries, Serbia and Turkey

Field of application:

This rule applies to senior PRM doctors trained or specialised in UEMS full member countries, Serbia and Turkey

Requirements:

Certification by equivalence is opened to senior PRM doctors trained or specialised in UEMS full member countries, Serbia and Turkey under the following criteria:

- Hold a basic medical qualification issued by a competent authority of a UEMS full member countries, Serbia and Turkey or certificate of equivalence issued by such an authority
- Having been trained as a medical PRM specialist in a UEMS full member countries, Serbia and Turkey
- Hold a valid qualification as a medical specialist in PRM issued by a competent authority of a UEMS full member countries, Serbia and Turkey or certificate of equivalence issued by such an authority
- Practice of the medical specialty of PRM in UEMS full member countries, Serbia and Turkey for at least 7 years
- Being able to document 250 CME / CPD credits collected from CME / CPD activities during the 5 years preceding the application

if the applicant complies to a national compulsory CME/CPD program of a UEMS full member country, Serbia and Turkey, she/he is not required to provide this proof of CME/CPD

- Cumulating at least 45 activity related points from the list of activities below:

Activity related points:

Clinical Experience:

- Work in a hospital or private practice as a medical PRM specialist
1.5 points / year and equivalent of full time employment
- Practise PRM as a leader of a multi-professional rehabilitation team comprising medical rehabilitation specialists and at least 4 professions allied to rehabilitation medicine from the following list: rehabilitation nurses, physiotherapists, occupational therapists, clinical



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psychologists, neuropsychologists, speech therapists, social workers, technicians for orthotics and prosthetics

1.5 points / year and equivalent of full time employment

Teaching activities:

Formal teaching of PRM subjects to medical students, PRM trainees or students for professions allied to Rehabilitation Medicine for more than 2 years at the time of the application

Hours of formal teaching per year	≥ 10 hours	≥ 20 hours
- to pregraduate medical students	2.5 point	5 points
- to postgraduate PRM trainees	2.5 point	5 points
- to pregraduate professions allied to PRM	1.5 point	3 points

Training activities up to a maximum of 15 points :

- Practice of PRM in a nationally recognized training centre for medical PRM specialists and involved in the clinical education of PRM specialist trainees
 - in a EBPRM certified training centre
1.5 points / year and equivalent of full time employment, up to a maximum of 15 points
 - in a training centre which is not certified by the EBPRM:
1 point / year and equivalent of full time employment, up to a maximum of 10 points

Activity in professional organisations of PRM medical specialists to a maximum of 10 points:

- Involvement in national, European or international professional organisations of PRM medical specialists:
 - as an executive committee member or committee chair person
1 point /organisation / year up to a maximum of 10 points
 - as a national delegate or expert
0.5 points /organisation / year up to a maximum of 5 points

Activity in rehabilitation or disability related patient's organisations up to a maximum of 10 points:

- Involvement in rehabilitation or disability related patient's organisations (NGO's) as medical advisor, executive committee member or committee chair person
 - Regional organisations 0.25 points/organisation/year up to 2 points
 - National organisations 0.5 points / organisation/year up to 5 points



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- International Organisations 0.5 points / organisation / year up to 5 points

Publications on PRM subjects up to a maximum of 35 points:

- For publications on PRM subjects, credit points are given according to the type of publication, the journal and the applicant's contribution:

First and last authors receive 100% of the credits points mentioned below, second and second last authors 50%. All other authors receive 25% of the credits points mentioned below.

PRM subjects (scientific, clinical or educational)		Original papers, meta-analysis	Review papers, case reports	Letters
International journals*	peer-reviewed	8	4	2
National PRM journals	peer-reviewed	4	2	1
National non PRM journals	peer-reviewed	3	1	0.5
International or national PRM journals	not peer-reviewed	1	0.5	0
	Authors of PRM related books	3	3	

* indexed in one of the main scientific databases: Pubmed/Medline, ISI-SCI, Excerpta etc.



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PRM related books or PRM subjects in books (scientific, clinical or educational)		in English	other language
Authors of PRM related books		30 per book	20 per book
Scientific editor of a PRM related book		30 per book divided by the number of editors	20 per book divided by the number of editors
Chapters in books *	review by editors	3	2
	not reviewed by editors	2	1.5
Master- MD- and PhD-thesis which are not printed as books	These credit points can't be awarded if the content has been published as papers in PRM journals and the credit points for these are claimed under « publications in scientific journals »	15	10 without English summary 15 with English summary

* First and last authors receive 100% of the credit points mentioned above, second and second last authors 50%, all other authors receive 25% of the credit points mentioned above.

Printed MD and PhD thesis on PRM subjects are considered as books.

In the case of a voluminous book or chapter the Jury of the European Board of PRM can increase the credit points up to the double of the credit points in the table above.



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Training Requirements for the Specialty of Physical and Rehabilitation Medicine *European Standards of Postgraduate Medical Specialist Training*

Preamble

The UEMS is a non-governmental organisation representing national associations of medical specialists at the European Level. With a current membership of 35 national associations and operating through 39 Specialist Sections and European Boards, the UEMS is committed to promote the free movement of medical specialists across Europe while ensuring the highest level of training which will pave the way to the improvement of quality of care for the benefit of all European citizens. The UEMS areas of expertise notably encompass Continuing Medical Education, Post Graduate Training and Quality Assurance.

It is the UEMS' conviction that the quality of medical care and expertise is directly linked to the quality of training provided to the medical professionals. Therefore, the UEMS committed itself to contribute to the improvement of medical training at the European level through the development of European Standards in the different medical disciplines. No matter where doctors are trained, they should have at least the same core competencies.

In 1994, the UEMS adopted its Charter on Post Graduate Training aiming at providing the recommendations at the European level for good medical training. Made up of six chapters, this Charter set the basis for the European approach in the field of Post Graduate Training. With five chapters being common to all specialties, this Charter provided a sixth chapter, known as “Chapter 6”, that each Specialist Section was to complete according to the specific needs of their discipline.

More than a decade after the introduction of this Charter, the UEMS Specialist Sections and European Boards have continued working on developing these European Standards in Medical training that reflects modern medical practice and current scientific findings. In doing so, the UEMS Specialist Sections and European Boards did not aimed to supersede the National Authorities' competence in defining the content of postgraduate training in their own State but rather to complement these and ensure that high quality training is provided across Europe.

At the European level, the legal mechanism ensuring the free movement of doctors through the recognition of their qualifications was established back in the 1970s by the European Union. Sectorial Directives were adopted, and one Directive addressed specifically the issue of medical Training at the European level. However, in 2005, the European Commission proposed to the European Parliament and Council to have a unique legal framework for the recognition of the Professional Qualifications to facilitate and improve the mobility of all workers throughout Europe. This Directive 2005/36/EC established the mechanism of automatic mutual recognition of qualifications for medical doctors according to training requirements within all Member States; this is based on the length of training in the Specialty and the title of qualification.

Given the long-standing experience of UEMS Specialist Sections and European Boards on the one hand and the European legal framework enabling Medical Specialists and Trainees to move from one country to another on the other hand, the UEMS is uniquely in position to provide specialty-based recommendations. The UEMS values professional competence as “*the habitual and judicious use of*



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*communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served*¹. While professional activity is regulated by national law in EU Member States, it is the UEMS understanding that it has to comply with International treaties and UN declarations on Human Rights as well as the WMA International Code of Medical Ethics.

This document derives from the previous Chapter 6 of the Training Charter and provides definitions of specialist competencies and procedures as well as how to document and assess them. For the sake of transparency and coherence, it has been renamed as “Training Requirements for the Specialty of X”. This document aims to provide the basic Training Requirements for each specialty and should be regularly updated by UEMS Specialist Sections and European Boards to reflect scientific and medical progress. The three-part structure of this documents reflects the UEMS approach to have a coherent pragmatic document not only for medical specialists but also for decision-makers at the National and European level interested in knowing more about medical specialist training.

Introduction

The scope and competencies of PRM specialty are best described starting from its definition as the “medicine of functioning” responsible of the rehabilitative strategy to be applied together with the curative strategy for the best recovery of patients’ participation; according to the complexity of the health condition, PRM also refers to prevention and maintenance, as well as to rehabilitation training for other health professionals and to management of patients and caregivers. PRM doctors are hence responsible for the planning of the rehabilitation process according to the so-called rehabilitation cycle: all patients require an assessment with definition of their individual goal(s) before providing the intervention(s); finally, an evaluation will be performed to check if the patient has achieved all what is needed, or if it is necessary to start again the rehabilitation cycle.

Under the perspective of a disease-centred approach, PRM specialists must develop progressive responsibility in diagnosing, assessing, and managing people of all ages suffering from (or at risk of) activity limitation / participation restriction following any disease condition.

Given such premises, the transversal role of PRM across most of the medical specialties is clear, but the overlap is only apparent, since the focus of PRM is rehabilitation.

For instance, diagnosis in PRM is the interaction between the classical medical diagnosis (that uses all the typical tools of the profession) and the PRM specific functional diagnosis, based on the ICF conceptual framework, and obtained through functional evaluations and clinical scales.

Interventions in PRM are provided directly by PRM physicians or indirectly through the PRM team. The multi-professional PRM team is the preferential way by which PRM physicians provide treatments, particularly in the most complex rehabilitation settings; the team works using an interdisciplinary methodology, under the responsibility of PRM physician.

The outcomes of PRM interventions and programs are measured both at the function level, as decreased impairments in body functions, and at the person level, as decreased activity limitations/participation restrictions; moreover, decreases in mortality, morbidity and complication rates as well as costs for hospital and community care are also outcomes of rehabilitation provision.

¹ Defining and Assessing Professional Competence, Dr Ronald M. Epstein and Dr Edward M. Houndert, Journal of American Medical Association, January 9, 2002, Vol 287 No 2



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Specialists in PRM have a holistic approach to people with acute and chronic conditions, examples of which are musculoskeletal and neurological disorders, amputations, pelvic organ dysfunction, cardio-respiratory insufficiency and the disability due to chronic pain and cancer. PRM specialists work in various facilities from acute care units to community settings. They use specific diagnostic assessment tools and carry out treatments including pharmacological, physical, technical, educational and vocational interventions. Because of their comprehensive training, they are best placed to be responsible for the activities of multi-professional teams in order to achieve optimal outcomes.

In summary, the medical specialty of Physical and Rehabilitation Medicine helps people with disabling conditions to recover maintain or develop the highest possible level of functional capacity and performance.

PRM in Europe

This document sets out standards and guidelines for PRM specialist training and for approval of training programmes in the countries of the EU/EFTA and associated member states. It is recognized that there are a number of structural and operational differences in the health care systems, appointment procedures and training systems in these different countries. This document provides the basis for the development of a harmonized, comprehensive, structured and balanced training programme in PRM.

The Central Monitoring Authority of the specialty of Physical and Rehabilitation Medicine in Europe is the UEMS Section and Board of Physical and Rehabilitation Medicine which produces guidelines for training in the specialty and a training programme blueprint to be filled in with the specific aspects of the training, pertinent to the individual EU/EFTA member states and associated member states. The Section of Physical Medicine and Rehabilitation was created within the UEMS in 1971. In 1991 a European Board of Physical Medicine and Rehabilitation was founded with the special mission to work towards harmonizing education and training in PRM in Europe. The European Board of PRM is running a European certification system including individual PRM specialists, trainers and training centres. The UEMS PRM Board holds a European Board Examination annually, open to candidates of the EU/EFTA member states and associate member states. The certification by examination is considered as seal of excellence without legal value but national authorities can adopt it as equivalent to or instead of their national exam or accept it as an exit exam if no national equivalent exists. The European PRM Board also provides recommendations for the requirements for training institutions and for those who are in charge of training in PRM, at a European level.

The UEMS PRM Board recommends that training institutions should have a system of visitation/external peer review and offers visitations of training. Having successfully completed a visitation the institution becomes an UEMS-Board certified centre for specialist training in PRM.

The UEMS PRM Section and Board work in strong cooperation with other two European bodies, e.g. the European Academy of Rehabilitation Medicine and the European Society of PRM.

Ideally every EU member state recognizing the specialty should have an independent professional specialist society of Physical and Rehabilitation Medicine. Man power planning and forthcoming quantitative training facilities are the responsibility of the national medical association on the advice of the national medical society of Physical and Rehabilitation Medicine. Therefore, the specialty of Physical and Rehabilitation Medicine should be represented in the national medical association in each EU country.

The present document contains a core curriculum for European PRM trainees. The structure of this description follows the format proposed by the UEMS.



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The endeavour of this document is to promote high standards of care for patients with (or at risk for) disability, throughout the European Union and sets the basic requirements in the domains listed below to enable specialists to move across European country borders for professional purposes.

The data that would be provided to a receiving country/employer about a doctor is shown in the Appendix at the End of this document.

Goals of the training programme

The primary goal of a training programme in PRM is to provide the trainee with a broad theoretical knowledge base, the necessary procedural skills and experience, as well as professional judgment for independent PRM practice and management skills for team-work. A further goal is to teach him/her self-criticism, critical assessment of his/her results, the ability to self-directed learning which will eventually lead to continued progression, expert practice and professionalism.

The different fields of competence and intervention of PRM specialists are typically described by categories taking into account the underlying medical conditions or the impaired body system. However, while acute care medicine/general medicine is centred very much on organs, diseases and mechanisms of injury based on the International Classification of disease - ICD model of medicine, PRM is mainly a function-centred medical specialty. Hence, the fields of competence and intervention of PRM specialists should be listed using function-related categories based on the International Classification of Functioning, Disability and Health – ICF. According to this model, PRM specialists need

- To achieve the **theoretical knowledge** of the biopsychosocial determinants of health and the complex interaction of factors that limit a disabled person's participation and autonomy in the context of their medical condition.
- To develop **the skill** to communicate this to the patient, the patient's family and to colleagues and the rehabilitation team so that there is an effective combined approach that is focused on the patient's particular priorities.
- To demonstrate highly **person-centred clinical practice** with an emphasis on assessment, planning and teaching in close liaison with team members and within a culture of empowerment and risk management.

TRAINING REQUIREMENTS FOR TRAINEES

Entry into the training programme for PRM depends on national regulations and should be transparent.

The number of trainees in national programmes should reflect the projected manpower needs in PRM. These depend on the organization of the national health care system and the demographics of the existing PRM manpower, which should be sufficient so that patients with disability (or at risk for developing disability) have timely access to specialist care. Trainees must have sufficient linguistic ability to be able to communicate with patients and colleagues. They should be able to work in the social and cultural context of the country in which they are based.

Adequate language, computer and internet skills are basic requirements for accessing and studying the international medical literature and communicating with foreign colleagues. Moreover, they must be able to communicate and work in an interdisciplinary multi-professional setting.



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Basic communication skills with patients and carers should have been acquired before entering specialty training and will be subject of continuous professional development. Experience with patient organizations is encouraged.

Basic knowledge of scientific methodology, skills in critical interpretation of study results and experience with current methods such as evidence-based medicine are required.

1. Content of training and learning outcome

a. Theoretical knowledge

Physical and Rehabilitation Medicine is the primary medical specialty responsible for the prevention, medical diagnosis, treatment and rehabilitation management of persons of all ages suffering from (or at risk of) any disabling health condition and its co-morbidities, specifically addressing their impairments and activity limitations in order to facilitate their physical and cognitive functioning (including behaviour), participation (including quality of life) and modifying personal and environmental factors.

To fulfil his/her role as PRM physician, the trainee should become familiar with the theoretical knowledge about the full spectrum of Body structure/Body function impairments, the mechanisms of tissue damage and repair, the principles of motor learning, the epidemiology and natural history of diseases, the tools for clinical, functional and instrumental diagnosis, the effects of pharmacological, surgical and complementary treatments, as well as of specific rehabilitation interventions.

More in detail, the trainee must develop knowledge and understanding of:

- Anatomy, Functional anatomy, Physiology, Biochemistry, Pathology and Physiopathology of the central and peripheral nervous system, the musculoskeletal system, and visceral systems.
- Biomechanics,
- Pharmacology
- Epidemiology
- Research methodology
- Ethics and Law
- Principles of Public and Global Health

b. Practical and clinical skills

Trainees must be exposed to the spectrum of disability conditions, as comprehensively as possible, during their training. This requires a tutorship by several trainers, and it is advisable that the scope of the training is broadened by working in different training centers/rehabilitation settings.

Competencies to be acquired during the training, or expected to have by the end of training, include:

- clinical and instrumental assessment to determine the pathophysiology mechanisms and the underlying diagnosis of the patient's condition.
- functional assessment in the frame of ICF, including assessment of body function/structure impairment, assessment of activity limitation and participation restriction and discrimination between capacity and performance, based on the detection of contextual (personal characteristics) and environmental barriers/facilitators
- implementation of clinical and instrumental assessment tools to explore motor, cognitive, behavioural and autonomic functions.
- prognosis of disease/disability course, detection of adverse/favourable factors of functional recovery and definition of the means (ways) of recovery, compensation and adaptation;



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- devising and conducting a rehabilitation plan, through a team-based approach that consists of setting achievable short, medium and long-term goals, agreed with the patient and carers, and eventually leading to patient's reintegration in the community and improved quality of life;
- prescription, as much evidence-based as possible, of medical and physical treatments (including drug treatment, physical modalities, innovative technologies, natural factors and others), as well as of technical aids (orthotics, prosthetics, wheelchairs and others), effective to achieve the goals of the rehabilitation plan;
- prevention and management of complications

c. Professionalism

PRM practice is uniquely characterized by a team-based, patient-centred, goal-directed approach aimed to optimize patient function and quality of life, prevent complications and increase community participation. Therefore, PRM specialists are required to develop not only medical knowledge, competence in patient care and specific procedural skills, but also attitudes towards interpersonal relationship and communication, profound understanding of the main principles of medical ethics and public health, ability to apply policies of care and prevention for disabled people, capacity to master strategies for reintegration of disabled people into society, apply principles of quality assurance and promote a practice-based continuous professional development. As leaders of the multi-professional rehabilitation teams involved in the continuum of care delivery from hospital to the community, they must also exhibit managerial competences, know and apply the principles of evidence-based medicine, incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate.

More in detail, a European PRM specialist is expected to exhibit behavioural features encompassing:

- leadership and teaching skills appropriate to coordinate and prioritize teamwork
- communication skills appropriate to convey relevant information and explanations to the patient/carers, to colleagues in charge of the patient and other health professionals with the objective of joint participation in the planning and implementation of continuous health care from the initial stage to the post-acute and steady state
- commitment to carrying out professional responsibilities and adherence to ethical principles, demonstrating compassion, integrity, and respect for others; responsiveness to patient needs, respect for patient privacy and autonomy, sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation
- active cooperation with the public health agencies and other bodies involved in the health care system, in the identification of the health needs of the community and the implementation of appropriate measures aimed at the preservation and promotion of health and healthy lifestyles and prevention of diseases
- ability to conduct programmes of therapeutic education for disabled people and caregivers.
- participation in the education of physicians and other professionals involved in care for disabled people.
- implementation of cost awareness and risk-benefit analysis in patient and/or population-based care
- ability to improve the quality of professional work through continuous learning and self-assessment, managing practice and career with the aim of professional development
- ability to apply the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care



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2. Organization of training

a. Schedule of training

In 1969 the WHO Expert Committee on Medical Rehabilitation published a report proposing a duration of training of 4 to 5 years for the medical specialty of PRM. Congruent, the PRM educational program in Europe is usually configured in 48-month format, rising up to 72 months in some countries, including a minimum 36 months of clinical training (of which 24 months spent in a PRM department).

However, considering the tremendous increase in life expectancy all over Europe, and the consequent increase in age-related disabling illnesses with acute onset and chronic course, the frequency and complexity of comorbidities in rehabilitation wards have markedly increased. Patients are admitted to wards much earlier after the onset of acute illness or injury and the complexity of the disabilities is also rising. For this reason, the UEMS PRM Section and Board advocate a duration of training of 60 months including 12 months rotations in external departments (like internal medicine, neurology, intensive care and others). Moreover, in order to provide patients with optimal care, PRM trainees are expected to develop decision-making abilities, based on finding, understanding and using the best available evidence. On such premise, it is recommended that PRM trainees are offered at least six months training in research methods, as a mandatory component of their postgraduate education. Rehabilitation is a complex activity and affected by multiple factors. Specific research methodology issues have to be learnt and applied in order to achieve those levels of evidence, in the scientific literature, that can help the specialty to flourish and compete successfully in future health economies. Hence, potential academics should be supported in pursuing PhD programmes within an appropriately staffed unit.

It is recommended that PRM training is spent in units approved as training institutions by their national responsible authority.

b. Curriculum of training

Curriculum of general and specific training periods

A written **Training Curriculum** must be designed to provide a diversified and balanced quality (theoretical and practical) of PRM education describing the contents and aims in each year of training. This must be available to trainees and the faculty. Emphasis should be placed on adequate time allocation for study and tuition independent of clinical duties. It may be necessary for some departments to formally organize specific training periods in associated rehabilitation units, if adequate experience cannot be provided internally.

There should be established rotation periods covering all main areas of PRM practice. These rotations should be organized in such a way as to give trainees increasing responsibility as they progress through their training with regard to patient care and professional experience. There should be a documented, continuous **Education Programme** throughout the training, which should include seminars, conferences and meetings at a regular basis (weekly, monthly, yearly).

This education programme should consist of

- a programme of lectures including visiting speakers
- clinical case discussion



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- journal clubs
- -research meetings
- regular teaching conferences (trainees should take increasing responsibility in the conferences and in the teaching of junior trainees, allied rehabilitation professionals, medical students)
- teaching in ethics, administration, management and economics.

Trainees should be encouraged and are expected to develop an understanding of research methodology. All trainees are expected to be able to assess published work. In academic programmes, the opportunity for clinical and/or basic research should be available to the trainee with appropriate faculty supervision. An appropriately qualified person should supervise specific research projects if applicable. There should be a protected period of time where a trainee can participate in a specific research project.

It is recommended that trainees attend the meetings of the national PRM society (or an equivalent meeting). If possible, trainees should participate in the training courses organized by the European Society of PRM or equivalent national and international training courses. During their training, they should also attend scientific meetings and hands-on-courses.

Trainees should keep a Logbook (Trainee Portfolio) containing details of all activities of the Education Programme in which he/she participated.

c. Assessment and evaluation

Logbook /Training Portfolio

Each trainee must keep an authorized Logbook that meets the standards of the UEMS logbook for documentation of professional experience. It will contain reports from the trainer giving an account of the trainee's active participation in the work of the unit, his/her publications, scientific and research works, including relevant theses.

The trainee will have to demonstrate that he/she has managed a wide range of cases. Logbook entries must be monitored by regular inspection and signed off by the appropriate trainer; copies of assessment forms for each training period completed and signed by trainers for that period should also be included.

The Logbook should be ready to be presented before the European Board certification or exhibited to a receiving country/employer, upon request, as a proof of the knowledge/skills achieved during postgraduate education.

The European Board attaches considerable importance in the details of the training programme as shown in the logbook.

Moreover, the trainee should be encouraged to keep a Training Portfolio, which should include an up-to-date curriculum vitae (EUROPASS style) incorporating:

- details of previous training posts, dates, duration and trainers
- details of examinations passed
- list of publications with copies of published first page or abstract
- list of research presentations at local, national and international meetings



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- list of courses attended

Periodic progress assessment

Training institutions should provide a system of appraisal – at entry into every part of the programme, at an intermediate point and at the end. A structured goal setting for each training period according to the curriculum at its evaluation is recommended.

The purpose of assessment is to ensure continuing progress in the trainee's knowledge and skills as well as professional conduct and ethics.

Trainees have to meet the agreed standards and requirements of the planned programme.

To this end, it is recommended that the trainee documents the following structured assessments:

- observed clinical skills (e.g. functional assessments, rehabilitation plans, active participation in team meetings)
- observed procedural skills (e.g. instrumental diagnostic procedures or invasive therapeutic interventions for treating pain or spasticity)
- case-based discussions

The minimal numbers of each of those items should be determined nationally

Assessment must be performed on an annual basis or at the end of each rotation period by the appropriate trainer, using an evaluation sheet. Clinical experience will be assessed by a review of the patients seen by a trainee and for whom the trainee has had a personal responsibility as regards care. The Logbook is used as supporting documentation. The result of the evaluation must be discussed with each trainee. Failure to meet the agreed targets must be brought to the attention of the training director.

It is the responsibility of the training director to identify any failure in a trainee's progress, to conduct and to provide appropriate advice, and to take remedial action. To this end, it is advised that trainees meet with their training director on a regular basis, namely every 6 months, to discuss their work. Such discussion will take the format of an appraisal with the trainee providing information about how he/she is progressing, accompanied by documented evidence of clinical engagement and achievement of learning and training outcomes. Moreover, the training director should take particular care of ascertaining the trainees' professional behaviour through the collection of multisource feedback, from trainers, other rehabilitation professionals, patients and caregivers.

In the event of a trainee not progressing as required, there are three stages of action:

- targeted training: closer monitoring and supervision to address particular needs
- intensified supervision and, if necessary, repetition of the appropriate part of the programme
- withdrawal of the trainee from the programme. This last measure should be reserved to persons that are not willing or not able to comply with the first two stages.

End of year / Exit examination



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At the end of PRM training, the Training Director certifies the attainment of adequate competency level for each training outcome.

The achievement of learning/training outcomes must be assessed at least on an annual basis by the Director of Training together with the faculty. Adequate permanent records of the evaluation must be maintained. Such records must be available in the trainee file and must be accessible to the trainee and other authorized personnel. The assessment must be objective and document progressive trainee performance improvement appropriate to their educational level. In particular, the final year examination must verify that the trainee has demonstrated sufficient competence to enter practice without direct supervision.

d. Governance

The governance of an individual's training programme will be the responsibility of the Training Director and the institution(s) in which the training program is being delivered. A trainer will be responsible to the training Director for delivering the required training in his/her area of practice.

II. TRAINING REQUIREMENTS FOR TRAINERS

1. Process for recognition as trainer

The standards for recognition of trainers are matters for national authorities, in accordance with national rules and EU legislation, as well as the requirements of the European Board of PRM. The latter has made recommendations for the optimum requirements to be met. It is recommended that the head of the training institute be a PRM Board Certified specialist.

a. Requested qualification and experience

To be recognized as a trainer, a physician should:

- Be certified as a specialist in PRM by the responsible national authority in his or her country.
- Be recognized as a trainer in PRM by the responsible national authority in his or her country.
- Have gained the recognition on the European Board of Physical & Rehabilitation Medicine through the holding of its diploma.
- Demonstrate his or her clinical activity as being within this discipline.
- Practice in the specialty for at least 80% of his or her time in an establishment recognized as a training centre by the national responsible authority over 5 years.
- Practice within a defined rehabilitation team.
- Actively participate in training and research in PRM with regular publications.

Those colleagues fulfilling the Board's criteria for trainer's status may apply for recognition as a Board-Certified specialist in PRM. Following the Board's assessment, they may gain exemption for the written examination on presenting their completed file with application form (Board Certification by Equivalence). This dispensation is extended to Board recognized as trainers-colleagues as well. In countries developing the speciality transitional arrangements may exist.

b. Core competencies for trainers

The Director of training has the overall responsibility for the training programme; he/she oversees and ensures the quality of didactic and clinical education and monitors resident supervision in all sites



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that participate in the educational program. He/she must exhibit PRM specialty expertise and be recognised as a trainer in PRM by the responsible national authority in his/her own country. It is also recommended that he/she has achieved the status of PRM Board certified trainer.

2. Quality management for trainers

On top of being regularly accredited as PRM physicians at national level, trainers should be PRM Board certified and should strive to keep abreast of the evolution of the discipline through a regular attendance to Congresses and Courses duly accredited for CME.

Teaching activity should be supervised and monitored by the training Director, whose responsibility encompasses identification of educational goals and the details of the educational components attributed to the trainers.

Contents and schedule of training program should be detailed in a written document presented to the trainees at the beginning of the training period and updated annually in relation to the changing educational needs and the specific needs of the training program.

Trainers will collaborate with trainees, the training Director and their institution to ensure that the delivery of training is optimal. They should meet at least twice a year with all trainees to openly discuss all aspects of training including the evaluation and approval of their log books and portfolios. The educational work of trainers and Director of training should be appraised annually within their Institution.

Educational support of trainers and Directors of training will be provided by their Institutions / Employers /PRM Scientific Societies and through the UEMS PRM Board.

III. TRAINING REQUIREMENTS FOR TRAINING INSTITUTIONS

(if not covered by EU Directive on Professional Qualifications)

1. Process for recognition as training centre

The education of PRM doctors to practice independently is experiential, and necessarily occurs within the context of the health care delivery system. Training must be realized in dedicated centres where qualified personnel and adequate resources are available. PRM training may take place in a single institution or in a network of institutions working together to provide training in the full spectrum of clinical conditions and skills detailed in the curriculum. The network should include a hospital or institution providing academic activity and recognized for training in internal medicine and general surgery/orthopaedics. Each participating institution in a network must be individually recognized at national level as a provider of a defined section of the curriculum.

a. Requirement on staff and clinical activities

To be recognized as a PRM training unit of European level, an institution/department must:

- Be recognized as a training facility in PRM by the responsible national authority in its Country.
- Be directed by a doctor, who is:
 - a specialist in PRM, recognized as a trainer by the European Board,
 - responsible for a team comprising: one more Board-certified specialist in PRM, professionals allied to medicine, including physiotherapists and occupational therapists as well as a group of other personnel (speech therapists, psychologists, social workers).



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- Contain the facilities to perform diagnostic assessments, functional investigation and measurement, and treatments relevant to the discipline of PRM.
- Maintain a network of contacts among clinical colleagues and professionals allied to medicine in hospital settings and services assisting the discharge of patients into the community.
- Show training activity:
 - in clinical domains through organizing of case presentations, symposium, staff meeting, journal club meeting,
 - in research work by trainee participation in the research activities of the unit

It would be unacceptable for a trainee to have only one trainer during their entire training period. It would be more usual for a trainee to have a number of named trainers with whom they work on a day-to-day basis. Each trainer would cover different aspects of a trainee's clinical training, but this individual will not be the only person who will provide educational support for a trainee.

NB. It is recommended that the number of trainees in any one unit does not exceed the number of available specialists in PRM for training. In countries developing the specialty transitional arrangements may exist.

The staff of a training centre will engage collaboratively in regular reviews of the centre's clinical activity and performance. There will be regular multi-disciplinary meetings to determine optimal care for patients and such meetings will involve both medical and other healthcare staff. There will be clinical engagement outside of the centre with other clinical groups such as orthopaedics, neurology, paediatrics, rheumatology, internal medicine, anaesthesiology and others

Within a PRM training centre there should be a wide range of clinical services available so that a trainee will be able to see and contribute to the care of all common sources of disability. In addition, the patient numbers and specialist numbers should be sufficient so that trainees will be able to be instructed and then supervised in the clinical procedures required of a specialist.

The balance between in-patient and out-patient numbers is constantly changing and varies across European countries depending on different care pathways adopted. Thus, no specific in- or out-patient numbers are stated as being necessary to be seen by a trainee during their training.

. Requirement on equipment, accommodation

The training unit must exhibit the availability of specific educational tools, particularly a library sufficiently stocked with PRM texts and works, which are kept up to date as well as audio-visual aids to teaching. Computing and Information Technology must also be available for online search of scientific papers.

2. Quality Management within Training institutions

a. Accreditation

Training centres must be recognized as a training facility in PRM by the responsible national authority. It is expected that training centres undergo regular audit within their country with respect to their clinical, scientific and educational activity; therefore, the audit would include data relating to the progress of trainees and their acquisition of specialist accreditation.

The UEMS-PRM Board will recognize a PRM department/centre as a European training centre after successful completion of their procedure of a European appraisal.



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b. Clinical Governance

Training centres should undertake internal audits of their performance as part of the requirements for continuing national accreditation. Any national evaluation of a training center's performance is expected to include the demonstration that it is:

- providing care for patients with a wide range of disabling health conditions
- providing educational and training support for trainees
- part of a healthcare system that provides immediate access to relevant laboratory and other investigations as well as providing when necessary immediate access to other clinical specialties that maybe required by their patients
- ensure the continuum of care

Training centres should keep records of the progress of their trainees.

c. Manpower planning

Among the task of the UEMS is to support national authorities with guidelines on the planning of medical manpower in any definite specialty. Each country should train only enough PRM physicians to meet its own requirements of specialist manpower. Trainees' recruitment in the training centres should be subordinated to the results of this planning; in any case the number of trainees present at any time in a training institution cannot exceed its clinical capacity to expose the trainees to the minimal number of procedures detailed in this document.

d. Regular report

The training institution must have an internal system of quality assurance including features such as mortality and morbidity and structured incident-reporting procedures. Furthermore, various hospital activities in the field of quality control such as infection control and drugs and therapeutic committees should exist. Visitation of training centres by the National Monitoring Authority or by the European PRM Board shall be conducted in a structured manner.

e. External auditing

The National Professional Monitoring Authority and/or the European PRM Board, together with the teachers and training institutions shall implement a policy of quality assurance of the training. This includes visits to training institutions, assessment during training, monitoring of log-books or other means. Visitation of training institutions by the National Monitoring Authority and/or the European PRM Board shall be conducted in a structured manner, according to the UEMS Charter on Site Visits.

Transparency of training programmes

It would be expected that a training centre would publish details of the training provision available with details of the clinical service it provides and the specialist and other staff. Such information would include the training programme, the nature of the clinical experiences with which a trainee would be engaged and the support and interaction with the trainer and Director of training. There would be a named individual whom a prospective trainee might contact and discuss the programme. The list of all training centres certified (accredited) by the European PRM Board is available on the EBPRM website.



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Curriculum of Studies in Physical and Rehabilitation Medicine

To be appointed as a specialist an individual should show a level of competence sufficient to allow independent clinical practice and to be able to care for patients at any stage of the disabling health condition. The level of performance may vary across European countries, and places; however, the list of theoretical knowledge issues and skills in this document describe the basic requirements one would expect of a European PRM physician.

A. General competencies

Upon completion of the specialization, Physical Medicine and Rehabilitation resident must:

- know and apply the principles of medical ethics and deontology
- possess professionalism, humanity and ethics with the obligation to maintain privacy and dignity of the patient
- be familiar with the art of dealing with patients, colleagues and other experts - communication skills
- know the importance of and be able to apply the principles of good cooperation with other health sector professionals
- be able to convey relevant information and explanations in a comprehensible and appropriate manner to the patient (verbally and in writing), to his family, to colleagues and other experts with the objective of joint participation in the planning and implementation of health care
- be able to define, screen and properly document the relevant information about the patient, to obtain information and take into account the views of colleagues and other experts
- improve the competencies and attitudes necessary to improve the quality of professional work through continuous learning and self-assessment
- adopt the principles of managing their practice and career with the aim of professional development
- develop the skills of transferring the knowledge to younger colleagues and other health sector professionals
- understand the importance of the scientific approach to the profession
- participate in scientific research while respecting ethical principles of scientific research and clinical trials and participate in the preparation of papers for publication

B. Specific competencies

A detailed list of learning outcomes to be achieved on completion of the postgraduate PRM course is presented, concerning both theoretical knowledge and practical skills. The list is comprehensive of all those issues relevant to PRM discipline. However, considering local variations in the duration of training, epidemiology of health conditions and related disability, it is possible that the learning outcomes will be achieved to a different level across European countries.

Therefore, emphasis is placed on basic foundational concepts and principles of PRM and the minimum standard of knowledge/skills to be achieved in such issues.

For applied clinical knowledge the following levels are used:

1. The trainee masters a thematic area on a basic level
2. The trainee has partially mastered a thematic area
3. The trainee has fully mastered the thematic area and is familiar with relevant literature



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For applied clinical skills the following levels are used:

1. The trainee needs help and supervision to work and solve the problems of the thematic area
2. The trainee needs partial professional supervision to work and solve the problems of the thematic area
3. The trainee is able to work independently and solve the problems of the thematic area.



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ANNEX II

CURRICULUM OF STUDIES AND THEORETICAL KNOWLEDGE FOR THE EUROPEAN BOARD DIPLOMA IN PRM

Content /Learning Unit	Standard levels to be achieved on completion of postgraduate course	
	Applied clinical knowledge	Applied clinical skill
CHAPTER 1. THE FUNDAMENTALS OF PRM		
Definition of function & health	3	
WHO Classification in detail: Body Structure and Functions, Activity and Participation, Environmental factors, Capacity and Performance concepts	3	
Epidemiology of disabling health conditions		
The rehabilitation process: principles and goals	3	
The rehabilitation project/plan and its main components	3	
How to collect patient's history according to the biopsychosocial model		3
How to conduct physical examination and functional assessment		3
Comprehensive PRM intervention definition: rehabilitation goal setting in the short, medium and long-term		3
Rehabilitation prescription writing 1 (exercise, orthotics, prosthetics, wheelchairs, assistive devices for ambulation, and other durable medical equipment or assistive devices)		3
Rehabilitation prescription writing 2 (evaluation and treatment by physical therapists, occupational therapists, speech/language pathologists, therapeutic recreational specialists, psychologists, and vocational counsellors)		3
CHAPTER 2. BODY STRUCTURES AND BODY FUNCTIONS (e.g. HUMAN ANATOMY, PHYSIOLOGY, APPLIED PHYSICS, BIOCHEMISTRY, BIOMECHANICS)		
Applied physics: forces, couples of forces, levers, moments, power, work, inertia, acceleration.	1	
Principles of behaviour and resistance of materials under force. A general understanding of strain and the effects of strain. Characteristics of homogeneous and composite materials.	1	
An elementary knowledge of the measurement of strain and deformity of various materials.		
Biomechanics: the biomechanics of the different tissues in the human body (particularly of the musculoskeletal system). An elementary knowledge of biomechanics of fluids and its application to fluids in the human body.	1	
Anatomy of the musculoskeletal system: joint structure, classification and characteristics of joint movements. Factors limiting the range of movement	3	
Muscle anatomy. Physiology of muscle contraction, mono and polyarticular muscles. Static or isometric contractions, dynamic or isokinetic contractions. Plyometric contractions.	3	
Agonists, antagonists, synergic muscle systems. Kinetic chains.		
Kinesiology: application to the human body of systems of levers; the different constituents of levers with relation to the musculoskeletal system.	3	



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Anatomy of the central, peripheral and autonomic nervous system. The neuromuscular junction.	3
Neurophysiology of posture, balance, goal-oriented and automatic movement	3
Mechanisms of motor learning. Experience and training-dependent neuroplasticity, cortical reorganization after brain lesion and motor recovery	3
Pain : anatomic and physiologic bases of pain transmission and perception.	
Genetic, cellular and molecular basis of pain and analgesia. Animal models of pain. Somatic and visceral pain. Interaction of pain and movement. Multidimensional nature of pain	3
Cardiovascular and respiratory functions	3
Biochemical effects of exercise. Energy expenditure, thermal regulation. Physiological costs, cardiovascular and pulmonary effects of exercise. Principles of cardiovascular fitness. Sports physiology.	3
Physiology of consciousness	2
Anatomical bases and neurophysiology of cognitive functions	2
Physiology of gastrointestinal and urogenital functions (mechanisms of swallowing and excretion)	3
Physiology of aging	3

CHAPTER 3. CLINICAL DIAGNOSIS AND FUNCTIONAL ASSESSMENT IN PRM:

How to assess and measure body structure/function impairment and their impact on activity limitation and participation restriction

(knowledge concerns the clinical use of selective clinical and instrumental measures, and the information provided.

Skills concern:

- the ability to administer selective clinical measures, interpreting the results and exploiting them for clinical decision making;
- the ability to prescribe selective instrumental investigations, interpreting the results and exploiting them for clinical decision making

- the ability to administer instrumental investigations marked with a star () is considered an advanced skill, not a standard

Psychometric properties of clinical measures and self-reported questionnaires (accuracy, reliability, validity, feasibility, ceiling and floor effect, transcultural validation)	3	
Clinical diagnosis and functional assessment of motor impairment: (measurement of range of motion, muscle strength, involuntary movements, muscle tone alterations with special focus on spasticity and dystonia)	3	3
Instrumental assessment of musculoskeletal lesions (plain X-ray, dual X-ray absorptiometry, ultrasound * , CT, MRI)	3	2
Clinical assessment of sensory impairment	3	3
Clinical assessment and functional diagnosis of impairment in axial motor features (trunk control, posture, balance and gait)	3	3
Clinical assessment and functional diagnosis of hand dexterity impairment	3	3
Quantitative instrumental assessment of motor impairment (electromyography*, nerve conduction studies*, motor evoked potentials*, posturography*, stabilometry*, computerized movement analysis*)	2	1-2
Assessment of pain through quantitative sensory testing and self-reported questionnaires of pain-related activity limitation/participation restriction.	3	3
Instrumental assessment of pain conditions (teletermography, neurophysiology testing of pain threshold*, diagnostic nerve blocks*)	2	1-2
Clinical assessment of consciousness impairment and coma severity	3	3
Instrumental assessment of brain/spinal cord lesions (CT, MRI)	3	2
Instrumental assessment of brain activity damage (EEG, evoked potentials, functional MRI*, PET, SPECT)	2	1-2
Clinical assessment and functional diagnosis of global and selective cognitive impairment and behavioural troubles	2	1-2



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Clinical assessment and functional diagnosis of global and selective learning disorders in developmental age	1	1
Clinical assessment and functional diagnosis of communication disorders	2	1-2
Clinical assessment and functional diagnosis of swallow disorders	3	2
Instrumental assessment of swallowing (e.g. fiberoptic endoscopy* , videofluoroscopy)	2	1
Clinical assessment and functional diagnosis of bladder and bowel dysfunctions	2	1
Instrumental assessment of bladder dysfunction (urodynamic testing*)	2	1
Clinical assessment of cardiopulmonary function impairment and reduced tolerance to effort	3	1-2
Instrumental assessment of cardiopulmonary function impairment (cardiopulmonary test* , spirometry*)	2	1
Laboratory testing	3	3
Assessment of independence in basic and instrumental activities of daily living	3	3
Assessment of patient-reported outcomes (quality of life, mood disorders, personal expectations and values)	3	3
Assessment of environmental factors and their influence on activity limitation/participation restrictions	3	2

CHAPTER 4. INTERVENTIONS IN PRM

Knowledge concerns Indications and evidence-based cost-to-benefit ratio;

Skills concern:

- indications and prescription/referral for intervention by allied health professionals based on the expected outcome and within the framework of the individual rehabilitation project/plan

- the direct administration of the intervention ().*

Therapeutic exercise: muscle (re)training, stimulation of muscle activity, task-oriented training. Techniques of muscle strengthening, endurance training	3	3
Manual therapy: manual and instrumental joint mobilization, lymphodrainage, massage	3	3
Joint manipulations*	3	2
Physiotherapy techniques: Neuromuscular facilitation-inhibition techniques, eg. Kabat, Bobath, Bronström, Voljta etc ...	3	3
Physical therapy modalities: Electrotherapy: galvanic currents; low, medium and high frequency treatment, Mechanical vibration, Biofeedback, Thermo- therapy (cold and heat treatment),	3	3
Balneotherapy	3	3
ECSWT: Extra-corporeal shock wave therapy. *	3	1
Pulmonary rehabilitation: Active and passive techniques of bronchial and postural drainage, manual clapping, instrumental techniques. Patient education and training.	3	3
Ventilatory aids. Not invasive ventilatory support, tracheostomy management. Equipment for assisted respiration.	3	1-2
Occupational therapy: fundamental ergonomics, principles and methods of occupational therapy, materials, equipment and technology in occupational therapy., applications of occupational therapy in functional rehabilitation and in reintegration into the community.	3	3
Orthotics (spine, limbs) and prosthetics (upper and lower limbs): knowledge of materials used in orthoses and prostheses and their mechanical properties	3	3
Locomotion aids/adaptive equipment: wheelchair advice and management	3	3
Assistive technology/ augmentative communication	3	2
Neuropsychological rehabilitation	2	2
Education, psychological support, biofeedback techniques	2	2
Reintegration of people with disabilities into society: vocational assessment, guidance and training, and methods to ensure financial security	3	2
Ergonomic considerations in the home, workplace		
Sports therapy	3	2



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Drug treatment: pharmacokinetics of drugs used in rehabilitation medicine; possible interactions with the rehabilitation programme and with therapeutic exercise. Sites, mechanisms of action and clinical use of analgesic drugs: opioids, NSAIDs and anti-thermic analgesics, Alpha-2 adrenergic agonists and cannabinoids, antidepressants and antiepileptic drugs, local anaesthetics Sites, mechanisms of action and clinical use of antispastic/spasmolytic drugs	3	3
Joint infiltration and injection techniques for pain management*	3	2
Muscle injection with Botulinum toxin for spasticity management*	3	1-2
Regional anaesthetic techniques, sensory nerve blocks and sympathetic blocks. *	3	1-2
Baclofen infusion pump management *	3	1
Neurostimulation techniques: Spinal, radicular and peripheral neurostimulation, Deep stimulation	3	1
Not invasive brain stimulation*	3	1
Radiofrequency lesions	3	1
Multidisciplinary pain management: Multidisciplinary Pain Units. Psycho-social aspects in patients with chronic musculoskeletal pain. Management of acute pain in the drug abuser and management of addiction in chronic pain sufferers	3	3
Music/art/pet therapy and other complementary/alternative medicine	3	2
Acupuncture*	2	1



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CHAPTER 5. REHABILITATION APPROACHES TO DISEASE –SPECIFIC DISABILITIES

Knowledge concerns: epidemiology, pathogenesis, clinical assessment, rehabilitation techniques, prognostic factors of recovery, for each health condition

Skills concern functional diagnosis and prognosis of functional recovery in the affected subject, planning the individual rehabilitation project, team work coordination, monitoring of intervention delivery and assessment of outcome, throughout the continuum of care in the inpatient and outpatient setting.

5.1 The immobile patient

Physiopathology of immobilization and its consequences on the Cardiovascular, Respiratory, Nutritional, Metabolic system (osteoporosis), Nephrological and urological system, Cutaneous system (skin-pressure sores), Musculoskeletal system (joint contractures, muscle wasting) and Nervous system (Learned non-use Cognitive decline-Mood and behaviour disorders)	3	3
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5.2 Nervous system disorders

Stroke	3	3
Traumatic Brain Injury in adults	3	3
Acquired brain injury in adults	3	3
Spinal cord injury (traumatic and non-traumatic)	3	3
Autoimmune & inflammatory neurological conditions (e.g. Multiple Sclerosis)	3	3
Movement Disorders (e.g. Parkinson's disease, Huntington's disease, dystonia)	3	2
Neuromuscular junction disease (e.g. myasthenia gravis)	2	1
Neuromuscular disease in adults (including post-polio syndrome)	3	1
Neuropathies and peripheral nerve injuries	3	3
Neuropathic pain conditions (diabetic and infectious neuropathies; post-amputation and post-spinal cord injury pain, plexopathies)	3	3
Focal disorders of Cognition and behaviour	3	2

5.3 Musculoskeletal Disorders

Osteoarthritis, crystal-induced & degenerative musculoskeletal conditions	3	3
Post-fracture and post-operative joint arthroplasty	3	3
Rheumatologic Disorders (Inflammatory & autoimmune disorders)	3	3
Musculoskeletal Injuries: muscle sprains and strains, joint dislocations,	3	3
Specific shoulder disorders	3	3
Specific hand and foot disorders	3	3
Spinal disorders (back pain, neck pain, scoliosis)	3	3
Temporo-mandibular joint disorders	3	1
Amputations (congenital and acquired Limb Loss)	3	3
Osteoporosis	3	3
Sports injuries.	3	3

5.4 Pain syndromes

Widespread pain syndromes: chronic fatigue syndrome, fibromyalgia, myofascial pain syndrome	3	3
Headache and facial pain	3	1
Complex regional Pain Syndromes	3	3
Visceral pain	3	3
Pelvic pain (including pelvic pain during intercourse)	3	1



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5.5 Respiratory and cardiovascular disorders

Acute and chronic obstructive and restrictive syndromes	3	3
Cardiac disorders. Valvulopathy, myocardial infarction, cardiomyopathies, cardiac surgery	3	3
Artero-venous system disorders: Lower limb arterial occlusive disease; deep venous thrombosis; ulcers, varicose ulcers.	3	3

5.6 Bladder and bowel disorders

Urinary stress incontinence, urge incontinence, urine leakage	3	2
Post-delivery or post-prostatectomy urinary loss,	3	2
Loss of stools or difficulty in evacuating them or anal pain when doing so.	3	2

5.7 Sexual disorders (after spinal cord injury)

3	2
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5.8 Cancer rehabilitation:

post-surgery complications in breast cancer, management of fatigue, promotion of healthy lifestyle and prevention of relapses, pain management and palliative care.	3	3
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5.9 Burn rehabilitation

Wound care and management	3	3
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CHAPTER 6. PRM approach to disabling conditions in the elderly

Knowledge concerns: epidemiology, pathogenesis, clinical assessment, rehabilitation techniques, prognostic factors of recovery, for each disabling health condition

Skills concern functional diagnosis and prognosis of functional recovery in the affected subject, planning the individual rehabilitation project, team work coordination, monitoring of intervention delivery and assessment of outcome, throughout the continuum of care in the inpatient and outpatient setting, with special attention to the early PRM intervention in the acute hospital stay, the involvement of family carers and social workers, the development of community rehabilitation projects aimed at preventing functional decline and complications.

The frail patient, comorbidities and polytherapy,	3	3
Postural instability and risk for falls,	3	3
Dementia and functional decline,	3	2
Pain management in the elderly	3	3

CHAPTER 7. PRM approach to disabling conditions in children.

Knowledge concerns: epidemiology, pathogenesis, clinical assessment, rehabilitation techniques, prognostic factors of recovery, for each disabling health condition

Skills concern functional diagnosis and prognosis of functional recovery in the affected subject, planning the individual rehabilitation project, team work coordination, monitoring of intervention delivery and assessment of outcome, throughout the continuum of care, adapting rehabilitation goals to the changing needs of disabled individuals during growth, also through the active involvement of parents, caregivers, school teachers and other education professionals

Troubles of psychomotor development and generalized/selective learning disorders	2	1
Cerebral palsy and the neuro orthopedic consequences of neurological disorders.	2	1
Dysraphic disorders (Spina bifida, myelomeningocele).	2	1



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Neuromuscular disorders.	2	1
Congenital malformation of musculoskeletal system (spine, limbs, skeletal agenesis, congenital aplasias and dysplasias; hip dysplasia, club foot, other foot malformations. lower limb discrepancy.	2	1
Idiopathic, congenital, secondary scoliosis	2	3
The consequences of acquired brain lesion in infancy	2	1
Amputations in children.	2	1
Pain management in children	2	1

CHAPTER 8. RESEARCH IN REHABILITATION

Knowledge concerns the theoretical bases of each thematic area and their relevance to clinical practice and research in PRM

Skills concern the ability to develop the different components of the research studies

Principles of epidemiology, quantitative and qualitative research	2	
Research study designs (experimental and observational studies, single-case studies, meta-analysis and reviews)	3	2
Fundamentals of inferential statistics (mean, SD, variance, confidence intervals, median, range, interquartile range; normal distribution)	3	1
Reporting results in graphics and tables, narrative assessment of outcome	3	2

CHAPTER 9. INTEGRATIVE AND CLINICAL REHABILITATION SCIENCES

Knowledge concerns the theoretical bases of each thematic area and their relevance to clinical practice in PRM

Skills concern the ability to transfer theoretical knowledge to clinical practice

Application of bioethical principles to decision making in the diagnosis and management of patients	3	3
Administration and management	3	3
A general idea on the health and medico social agencies in the different countries of the European Community: Health Insurance Systems Social Security. Hospitalisation, private and public. Hospitalisation at home. Domiciliary care, health workers, home helps. Assistance and surveillance by telephone and other telecommunication methods.	3	
Research on best care including guidelines, organization, coordination, and education	3	2
Standards and guidelines for the provision of best care (including Evidence Based Medicine) in PRM	3	
PRM quality management	3	3
Scientific education and training of professionals in PRM	3	2
Development and evaluation of the PRM team and multidisciplinary care	3	3
Community-based rehabilitation issues	3	
Networks and pathways in PRM	3	



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CORE COMPETENCIES

The following key competencies should be integrated in the curriculum. These are outcomes or competencies that a resident/trainee is expected to have achieved by the end of the training program in preparation for the independent practice of Physical & Rehabilitation Medicine (PRM). Competency descriptions may be applicable to more than one domain.

DOMAINS	COMPETENCIES TO BE ACHIEVED
Patient safety and quality of care	<ul style="list-style-type: none"> • Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health • Demonstrate competence in the evaluation and management of patients with physical and/or cognitive impairments, disabilities and functional limitations across different age groups • Understand and provide appropriate prescription/consultation for evaluation and management by other rehabilitation professionals (e.g. Physical therapy, occupational therapy, Speech/language pathologist, therapeutic/recreational specialist, psychologists and vocational counselors), while overseeing and monitoring the rehabilitation program • Work in inter-professional teams • Coordinate effectively and efficiently an interdisciplinary team of allied rehabilitation professionals for the maximum benefit of the patient through: <ul style="list-style-type: none"> • An understanding of each allied health professional's role • The ability to write adequately detailed prescriptions based on functional goals for psychiatric management • The development of management and leadership skills • Be able to assess the needs of a patient hospitalized in an acute care facility and suggest an adequate treatment/recommendation • Organize admission to a rehabilitation facility • Organize the discharge from a rehabilitation facility, relaying by ambulatory care, including the establishment and coordination of measures for disability compensation • Have experience in the continuing care of patients with long-term disabilities through appropriate follow-up care • Assessment of risk and prevention of avoidable complications • Identification and appropriate management / referral of medical emergencies • Identification and appropriate management / referral of patients approaching the end of life. Negotiation and communication of advance care plans and limitations to treatment
Medical Knowledge and Procedural Skills	<ul style="list-style-type: none"> • Demonstrate understanding of the pathophysiologic aspects, risk factors and functional prognosis of disorders in PRM, and describe the deficiencies, activity limitations and participation restrictions as consequences of such disorders • Utilize appropriate diagnostic and assessments, both clinical and technical means, to explore functions, with eventual development of a rehabilitation management plan using pharmacologic and non-pharmacologic, physical, cognitive and behavioral treatments, as well as means for disease prevention • Independently perform comprehensive and specific psychiatric examinations, including diagnostic and treatment procedures common to the practice of PRM • Identify the different kinds of exercise prescribed by a PRM specialist.



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Interpersonal Skills and Communication	<ul style="list-style-type: none"> • Demonstrate interpersonal and communication skills that result in effective exchange of information and collaboration with patients, their families, and other health professionals. • Exhibit effective and appropriate communication with patients, families, and the public, across different socioeconomic and cultural backgrounds. • Work effectively as a member or leader of a healthcare team or other professional group; and act as a consultative role to other physicians or health professionals. • Maintain comprehensive, timely and legible medical records
Practice and Systems-Based Learning	<ul style="list-style-type: none"> • Observe and gain fundamental understanding of the types of patients served, referral patterns and services available in the continuum of rehabilitation care in community rehabilitation facilities. These might include subacute units and skilled nursing facilities, sheltered workshops and other vocational facilities, schools for persons with multiple handicaps, including deafness and blindness, independent living facilities for individuals with severe physical impairments, day hospitals, and home health care services, and community-based rehabilitation. Introduction to these options for care may be made by on-site visits to some of these facilities as well as didactic lectures. Residents should be encouraged to interact with health care consumer groups and organizations in supervised working environments • Identify the inclusion criteria for a physical/cognitive rehabilitation program for an older adult and criteria for discharge. • Identify the main relevant patient groups for a disabled person.
Reintegration of people with disabilities into society	<ul style="list-style-type: none"> • Identify resources of education and training for a disabled person and participate in the orientation • Identify resources of professional rehabilitation and participate in the orientation for reintegration • Advocate for quality patient care and optimal patient care systems • Identify the health, social and financial resources specific to older adults • Identify and establish the means allowing a disabled person to remain at home
Medical Ethics and Public Health	<ul style="list-style-type: none"> • Identify individual and collective issues of public health and ethics related to disabled people. • Identify clinical situations (during rehabilitation) of unreasonable obstinacy related to care. Conduct, within the rules and deontology (normative ethical position), multi-professional discussions aiming at care limitations with the patient and relatives/caregivers. • Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate • Assessment of capacity and multiagency determination of best interest of the patient
Quality Assurance	<ul style="list-style-type: none"> • Participate in identifying system errors and implementing potential systems solutions • Receive formal instruction regarding the principles, objectives and process of performance improvement and program evaluation, risk management and cost effectiveness in medicine
Policies of care and prevention for disabled people.	<ul style="list-style-type: none"> • Codify PRM clinical activities and practical procedures. • Participate in public information about prevention and care for the main disabling diseases and the social integration of disabled people.
Professionalism	<ul style="list-style-type: none"> • Demonstrate a commitment to carry out professional responsibilities and an adherence to ethical principles • Demonstrate compassion, integrity and respect for others • Respect for patient privacy and autonomy • Demonstrate responsiveness to patient needs that supersedes self-interest



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- Accountability to patients, society and the profession
- Be sensitive and responsive to a diverse patient population, including, but not limited to diversity in gender, age, culture, race, religion, disabilities and sexual orientation.

Appendix

Data to be provided to a receiving country about a doctor.

Record of clinical work and clinical skills

When a doctor seeks to gain employment in an EU country other than his/her own (or the one in which he/she has been trained) he/she will be required to provide access to appropriate records (logbook) demonstrating the extent and nature of his/her clinical experience and skills to a future potential employer and any other relevant body (for example a statutory medical body that grants employment rights within a country).

Independent confirmation of progress of a trainee (or of work as a specialist)

Doctors seeking to gain employment in a country other than their own or the country in which they have been trained will be required to provide references to the following details:

1. The curriculum that the trainee has followed
2. The nature of assessments completed by the trainee and the outcomes of any assessments undertaken by him/her
3. The outcomes of assessments of a trainee's professional behaviours
4. The good standing of the trainee
5. The nature of the quality assurance processes by which it is known locally that the quality of the curriculum and its delivery are satisfactory
6. As regards a specialist seeking to work in another country, references will be required to contain confirmation regarding an individual's clinical experience and good-standing, including outcomes of any assessments of professional behaviours.