

GUEST EDITORIAL

2012 – An ISPRM Landmark Year

In 2012, ISPRM has implemented a new governance and a new organizational structure which have been developed over the last 4 years, based on the strategic plan outlined in a previously published special report of this journal (1, 2). The mid-term meeting of ISPRM in Atlanta in November 2012, hosted by AAPMR, was an important landmark in the development of our society. Accordingly, we have given this year's information from the president's cabinet the title "2012 – An ISPRM Landmark Year".

In this paper, we review key elements of this landmark year and present the current and revised policy agenda.

NEW GOVERNANCE

The development and implementation of a more democratic governance was one of the essential goals of ISPRM's way forward (1, 2). Most importantly, this includes the election of 9 representatives of the national societies and 3 representatives of the individual members to the executive board. It also includes the election of 15 representatives of the individual members to the assembly of delegates. This significantly strengthens the involvement of national societies and individual members in all decision-making bodies and processes of the society.

The architecture of the 3 ISPRM areas and 9 subareas, as shown in Fig. 1 and described in Table I, which in principle was approved in previous years, forms the geographical basis for the election

of the representatives of the national societies and individual members. This architecture will also be used for other activities that require equal distribution of activities around the world (e.g. scientific committee and World Congresses). The elected representatives of the national societies are listed in Table II.

As can be seen in Table II, there were no candidates or valid elections for two subareas, Africa and South America. We expect representatives for the national societies in South America and Africa to be elected in the next election in two years. Unfortunately, the election of representatives of the individual members could not be successfully implemented in Atlanta. The reason was that the quorum of at least 5% of individual members being present could not be achieved.

In a retreat after the Atlanta ISPRM meeting, the president's cabinet proposed to review the election procedure for the election of individual members. The president's cabinet also suggested that the development of a new and revised procedure should be completed in the context of an emerging membership model, which is likely to have an impact on the individual membership.

On January and February, 2013, an electronic voting procedure was successfully performed and the representatives of the individual members (except one for the Americas), and the chair of the Assembly of Individual Members were elected.

The new procedure for the election of vice president, secretary, and treasurer was implemented by the nominating

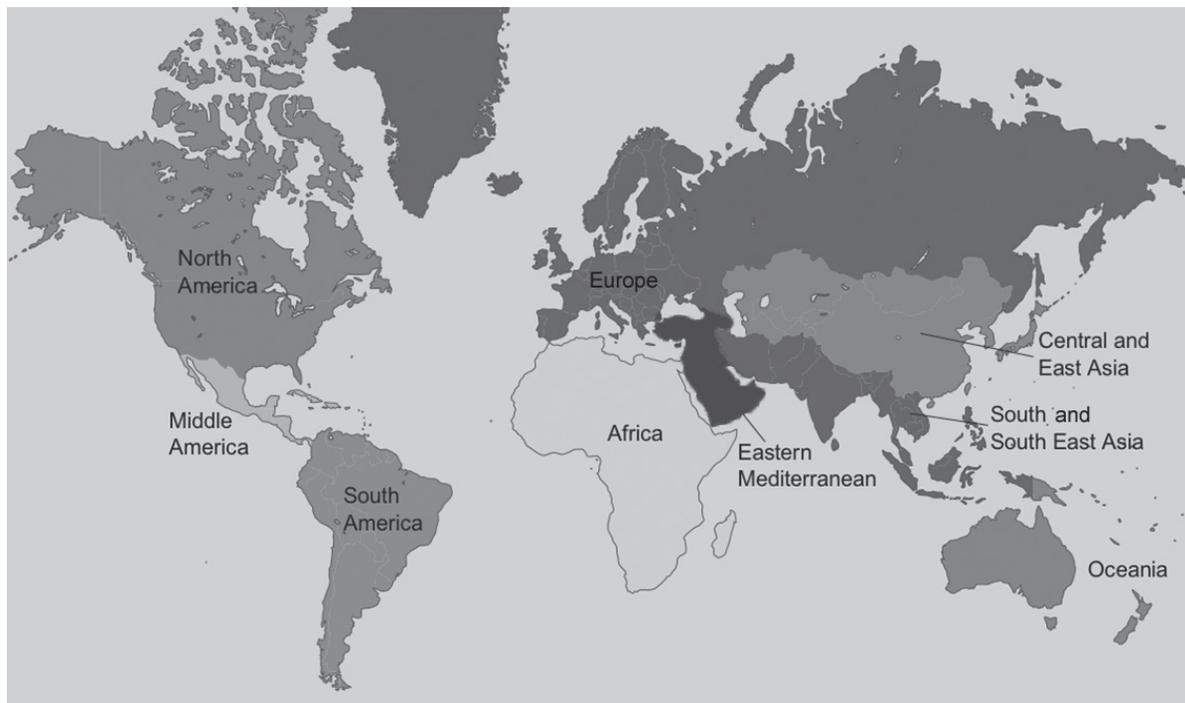


Fig. 1. Map of ISPRM World Areas (a list of countries is available on www.isprm.org).

Table I. ISPRM World Areas and corresponding WHO and United Nations (UN) regions

WHO and UN regions and subregions		ISPRM areas and subareas	
WHO Regions ^a	UN Subregions ^b	ISPRM World Areas	ISPRM Subareas
Region of the Americas	North America Central America and Caribbean South America	The Americas	North America Middle America South America
European region	Northern Europe, Western Europe, Southern Europe and Eastern Europe	Europe, Eastern Mediterranean and Africa	Europe ^c
Eastern Mediterranean region	Western Asia		Eastern Mediterranean ^d (Western Asia) Africa
African region	Northern Africa, Western Africa, Middle Africa, Eastern Africa and Southern Africa		
South East Asia region	Central Asia and Eastern Asia	Asia and Oceania	Central and East Asia
Western Pacific region	Southern Asia and South-eastern Asia Micronesia, Melanesia, Polynesia and Australia and New Zealand		South and South East Asia Oceania ^e

^awww.who.int/about/brochure_en.pdf (Sept 18th, 2012).

^bunstats.un.org/unsd/methods/m49/m49regin.htm (Sept 18th, 2012); this documents provides a list of included countries.

^cIsrael in ISPRM is part of Europe.

^din this case WHO terminology was used.

^ethe term "Oceania" was used because it is established in PRM (name: "AOSPRM").

committee for the first time in Atlanta. It involved a call for applications and an evaluation of the applications by the members of the nominating committee. Following this procedure, for the first time, several candidates applied and presented themselves to the assembly for election. In the retreat of the president's cabinet after the Atlanta mid-term meeting, it was proposed to further develop the procedures for the election of vice-president, secretary and treasurer in light of the experience of Atlanta. Most importantly, it was suggested that in the future, nominations can only be made to the nominating committee and no longer during the assembly of delegates. It was further suggested that the nominating committee will present all candidacies to the assembly of delegates and make a recommendation. All candidates will be informed about the recommendations in advance and will have the possibility to withdraw their candidacy prior to the election.

During the assembly of delegates, the membership committee raised the issue of membership and voting rights for countries where there is more than one society. The president's cabinet in its retreat felt that it should be possible that more than one society of a country can become a member of ISPRM. With respect to the voting rights for countries with more than one society, the president's cabinet will closely work with the membership committee and establish a proposal to be voted on during the Beijing congress.

Table II. Representatives of National Societies as elected in Atlanta, November 2011

William Micheo (USA)	North America
Juan Manuel Guzman Gonzalez (Mexico)	Middle America
Merce Avellanet Viladomat (Spain)	Europe
Maher Saad Al Jadid (Saudi Arabia)	Africa & Middle East
Lydia Latif (Malaysia)	Southern & South East Asia
Simon Fuk-Tan Tang (Chinese Taipei)	Central & East Asia
Andrew Cole (Australia)	Central & East Asia

KENES INTERNATIONAL, NEW CENTRAL OFFICE

In Atlanta, our new central office, Kenes International, managed our ISPRM meetings for the first time. The leadership of ISPRM acknowledged the tremendous effort the Kenes team has made to ensure the transition to the new central office based in Geneva, Switzerland. It also acknowledged the major efforts that have been made towards the registration of our society as a non-governmental organization at the chamber of commerce in Geneva. At this point, the central office has responded to all requests from the chamber of commerce and we are looking forward to the registration of our society in Switzerland.

KUALA LUMPUR, MALAYSIA: FIRST ISPRM WORLD CONGRESS ORGANIZED BY KENES INTERNATIONAL

Atlanta 2012 was the last so-called mid-term meeting. From 2013 on, ISPRM will hold yearly conferences, first in Beijing, China, 2013, followed by Cancun, Mexico, 2014 and Berlin, Germany, 2015. From 2016 on, ISPRM will organize its own congress through its professional congress organizer, Kenes International. Congresses still will be hosted by a national society. ISPRM welcomes also regional societies in mutual recognition with ISPRM to participate in the congress organization in their region, preferably in conjunction with the regional meeting.

According to the ISPRM statutes and policies and procedures, the congress site for 2016 was chosen during the ISPRM mid-term meeting in Atlanta. Four countries applied. According to a technical analysis by Kenes International, all 4 proposed congress sites were valid and offered a highly attractive setting. The assembly of delegates voted to hold the 2016 congress in Kuala Lumpur, Malaysia. During our next congress in Beijing 2013, the assembly will vote on the congress location in the ISPRM area of the Americas in 2017. During the 2014 ISPRM

World Congress in Cancun, the assembly of delegates will vote on the congress site of the 2018 Congress that will be held within the ISPRM area of Europe, Eastern Mediterranean and Africa. Potential candidates are encouraged to contact our central office at Kenes regarding the congress requirements (www.isprm.org).

CONGRESS STRUCTURE

Starting with the 2013 World Congress in Beijing, congresses will be organized in a more uniform way ensuring better orientation for participants and, in particular, a continuous communication of researches with mutual interests. To reach this goal an ISPRM-topic list has been developed (3) following the structure of the scientific bases of the field of Physical and Rehabilitation Medicine (PRM) (4). It includes the following 5 areas: biosciences in rehabilitation, biomedical rehabilitation and engineering, clinical PRM, integrative rehabilitation, and human functioning. Additionally, other contemporary topics of interest will be included in the scientific program of the congresses. Finally, at least one session will be dedicated to the Liaison with WHO and organized in cooperation with this organization.

To ensure a high quality scientific program, an ISPRM-scientific committee will be established to assume the responsibility for the scientific content. Besides the congress president, scientists from all ISPRM subareas will be nominated, 2 from each sub-region. To ensure continuity, every year 3 committee members will be replaced. The second principle for the nomination of scientific committee members is that, for all research areas, internationally recognized experts will be appointed. This scientific committee structure will be implemented starting 2015 in Berlin.

In the retreat after the Atlanta ISPRM one of the authors (CG) emphasized the need to collaborate with the national societies by having, for example, sessions in several WHO languages. This will be implemented for the 2015 ISPRM congress of Berlin.

COMMITTEES

For the first time, all ISPRM committees met in a pre-defined and systematic way gathering for 1.5 h workshops each in Atlanta. With the increasing and successful committee work, the planning of the committee meetings during the ISPRM congresses will be of utmost importance. Also, committees are encouraged to hold at least bi-monthly phone conferences involving all committee members. With regard to committee governance and operations, ISPRM leadership developed principles during its strategic workshop which was held in January 2013. This involved for example the administrative support for committee work, the management of funds for specific committees, the procedural and monitoring systems for committee activities, as well as the relationship of committees to external organizations.

There were a number of committee-related motions during the Atlanta meeting. The motion by the WHO–ISPRM liaison committee to adopt the ICF-based conceptual descriptions

of rehabilitation as a health strategy (5) and of Physical and Rehabilitation Medicine (6) was approved. The conceptual descriptions, together with some practical examples (so-called “use cases”) will be discussed in a separate publication in the official journal of ISPRM.

The motion to create a new committee named “Clinical Sciences Committee” was also approved. Over the next year, the designated committee chair will organize the committee interest groups in line with our topic list and the organization of one of our educational tools, the MediGrip® (www.medgrip.org). Table III shows the currently envisioned interest groups. The most important principles of the Clinical Sciences Committee is the involvement of mentors and mentees and the development of suitable clinical standards based on a review of guidelines from the different ISPRM areas.

Another important change of the committee structure concerns the ISPRM–WHO liaison committee. According to the collaboration plan with WHO a new sub-committee will be established. It will work on community-based rehabilitation guidelines. Especially here the ISPRM–WHO liaison Committee policy is to involve ISPRM members from lower income countries. The first gathering of this subcommittee will be held in Beijing 2013. To avoid having too many sub-committees and to promote collaboration among them the subcommittees for the implementation of the UN-convention for the Rights of People with Disabilities and the World Report on Disability will be merged into one sub-committee.

MUTUAL RECOGNITION OF ISPRM AND REGIONAL ORGANIZATIONS

One of the most important issues with respect to our governance is the development of a fruitful collaboration with regional societies. In this context it is important to recall that ISPRM membership structure includes national societies and individual members. However, regional societies are not members of ISPRM. Therefore, it has been suggested to develop joint workplans in the context of a mutual recognition contract (1, 2). These workplans include topics of recent interest following all 3 mandates of ISPRM (humanitarian, scientific and professional). Currently, the mutual recognition contract has been signed by

Table III. *Propose List of Special Interest Groups within the new Clinical Sciences Committee*

No.	Topic	No from ISPRM Topic list (3)
1.	Pain & musculoskeletal conditions, including trauma and amputation	A.1, A.2 & A.7.3
2.	Acquired brain injury	A.3.1. & A.3.2
3.	Spinal cord injury	A.3.3
4.	Autoimmune, inflammatory and neurodegenerative disorders	A.3.4., A.3.5 & A.3.8
5.	Heart, cardiovascular pulmonary and metabolic diseases	A.4.1., A.4.2 & A.4.5
6.	Geriatrics and Cancer	A.6. & A.4.4
7.	Pediatrics	A.5

ISPRM in collaboration with the 4 European bodies of PRM (European Society for Physical and Rehabilitation Medicine (ESPRM), the UEMS-PRM Section & Board, the European Academy for Rehabilitation Medicine (EARM)), as well as with the Latin-American Association for Medical Rehabilitation (AMLAR). Table IV shows the work plan of the mutual recognition contract. Similar work plans and mutual recognition agreements are currently being developed in collaboration with Asia-Oceania Society for PRM (AOSPRM) and the Pan Arabic Association of Physical Medicine and Rehabilitation (PARM).

JOURNAL OF REHABILITATION MEDICINE

ISPRM follows two avenues to strengthen our specialty through collaboration with journals. The first is our “Web of Journals”, the second is our official international journal, the Journal of Rehabilitation Medicine. In Atlanta, the French Journal of PRM was accepted as a journal “published in association with ISPRM” and the Chinese Journal of PRM as well as Annals of Physical and Rehabilitation Medicine were accepted as a journal “endorsed by ISPRM”.

REVISED POLICY AGENDA

Table V shows the updated policy agenda of ISPRM. The policy agenda serves as a guide for our membership and most importantly for our committees. It provides an overview regarding our main activities and serves as guide for the two-yearly renewal of our work plan in collaboration with WHO.

PRINCIPLES AND PRACTICE OF CLINICAL RESEARCH HARVARD SÃO PAULO PROGRAM, CALL FOR NOMINATION OF ATTENDEES

One of the most important programs of ISPRM to aid young PRM investigators in their development has been and will continue to be the Harvard Sao Paulo program. It is important to note that a number of alumni are now active in committees including the executive committee of ISPRM. Therefore it is crucial that

national societies nominate their candidates for the Harvard Sao Paulo program and to support their development as young investigators with an interest in international collaboration. For information regarding the Harvard Sao Paulo program, please contact our Central Office at Kenes International.

EMERGING ISSUES

The leadership of ISPRM has identified a number of important issues that will require our attention over the next two years. They include among others the collaboration with industry and societies from other specialties. Others are the development of research, which is addressed through our task force and now the Clinical Sciences Committee. Finally, ISPRM is envisioning using the media for developing educational and training programs.

Based on the working plan of the period from 2010 to 2012 an updated workplan has been set up (Table V). It will be published in extenso soon (7). It on the one hand includes the following through of the working tasks in relation to WHO, the improvement of ISPRM’s internal working structures and some new points related to building up appropriate rehabilitation structures all around the world as well as defining important questions for future research.

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Table IV. Mutual recognition work plan

	ISPRM mandate	Related work plan
1.	Humanitarian mandate	Analysis and implementation of the World Report on Disability: analysis of the impact on the regional situation and development of guidelines for the implementation into health strategies. Implementation of ICF: e.g. ISPRM proposes to facilitate the recruitment of experts for the project to describe the functional properties of the 100 most frequent diseases in rehabilitation and the ISPRM project to develop an ICF-based tool to measure functioning and disability.
2.	Professional mandate	Contribute to the development of ISPRM definitions for functional syndromes and clinical guidelines for its PRM treatment and management. Discussion about the conceptual descriptions of rehabilitation as a health strategy and of PRM as well as the rehabilitation service matrix including the development of use-cases.
3.	Scientific mandate	Connect PRM journals from the respective region to the ISPRM web of journals. Appointing at least 3 members nominated by the 4 European Bodies and AMLAR to the scientific committee of the 9 th World Congress of the ISPRM in Berlin 2015 and organising a session in the respective world in the 9 th World Congress of the ISPRM in Berlin 2015.

PRM: Physical and Rehabilitation Medicine; AMLAR: Latin American Medical Association for Rehabilitation.

Table V. ISPRM policy agenda for the years 2012 to 2013

Strategic goal	ISPRM activities	Status of ISPRM activity
1. Enhancement of collaboration with regional PRM societies	Establishment of mutual recognition and collaboration plans with regional PRM societies (following the model of the WHO DAR/ISPRM collaboration plan)	Mutual recognition agreements between ISPRM and the European PRM Bodies (ESPRM, UEMS-PRM Section and Board, EARM) as well as the AMLAR have been signed. A similar agreement with the AOSPRM and PARM is under negotiation
2. Improve organisation structure and internal management of ISPRM	ISPRM's activities will be managed more effectively. Information will be provided for members and executives. This includes among others update of databases such as membership lists, tracking working processes and information management. Additionally fund raising and sponsorship will be optimized	After signature of cooperation Kenes international works on an improvement of all managerial processes within ISPRM
3. Enhancement of ISPRM congresses	Enhanced involvement of central offices in ISPRM congresses and of ISPRM officials in scientific committees and programmes	From 2016 onwards all World Congresses will be organised under the responsibility of Kenes international as PCO. New congress standards will be implemented step by step from the 2013 Congress on. The scientific programme will be structured according to the new ISPRM topic list. An ISPRM scientific committee will be established consisting of members from all 9 ISPRM subareas. The ISPRM scientific committee will have regular meetings
4. Improvement of network of scientific cooperation and publication organs	1. ISPRM aims at creation of a network of scientific journals in order to provide enough journals for peer reviewed publication in the field and its subfields as well as to avoid self-citation 2. Additionally the exchange of young scientists will be supported by ISPRM	1. Besides of the official journal, ISPRM collaborates with a number of peer-reviewed scientific journals either as endorsement or association 2. An exchange program for young scientists has been established. Both activities are followed up continuously
5. Democratization of ISPRM governance structure and election procedures	Creation of Individual Members Assembly and move from nomination and approval to election of representatives by Assembly of Delegates. Election of 3 representatives of individual members (1 per ISPRM world area) and 9 representatives of national members (3 per ISPRM world area) into Executive Committee by Assembly of Delegates to replace previous ISPRM regional vice-presidents	After the decision of the new structure it is step by step put into practice starting from the elections in the interim meeting in Atlanta 2012
6. Supporting the establishment of rehabilitation services worldwide	1. Discussion paper with working title "ISPRM's potential roles in fostering the establishment of PRM services in low resourced settings" 2. New items for WHO DAR/ISPRM collaboration plan have been proposed by ISPRM 3. Minimum requirements will be defined for rehabilitation physicians and other health professionals involved in rehabilitation services. These requirements will give support to developing countries to establish effective rehabilitation services 4. Structural models will be provided for the development of rehabilitations services in countries with different development levels	1. Discussion paper currently under technical review by the WHO liaison committee 2. Proposed new WHO DAR/ISPRM collaboration plan currently under review by the WHO 3. A task force will elaborate minimum requirements for education of rehabilitation physicians and other health professionals active in rehabilitation services 4. Structural models will be developed based on a new classification approach for medical services and collaboration of the new subcommittee on "Community-delivered Rehabilitation") and based on WHO's CBR guidelines
7. Developing rapid rehabilitation response to natural and man-made disaster	Conceptualisation of ISPRM for natural disaster relief strategies and scientific founding for such concepts	1. Publication of conception papers and sessions about natural disaster relief in scientific meetings 2. Development of a concept of a interventional task force in close cooperation with WHO
8. Enhancement of research capacity	1. Establishment of a clinical science committee and identification of scientific topics with high priority 2. Develop and implement educational structures to increase scientific work capacity	1. A new clinical sciences committee has been established in 2012 and will develop a working agenda until June 2013. Special interest groups for concrete work will be founded 2. Harvard educational courses on principles and practice of clinical research have been implemented. Additional projects will be developed 3. Regular reviews will be provided in MediGrip®. Its concept will be enhanced until 2014
9. Development of ISPRM constituency and membership	1. Facilitation of foundation of PRM societies 2. Development of new membership models	1. PRM societies in low-resource settings: Identification of white spots provided in discussion paper; development of strategies to support the foundation of new scientific societies 2. New membership models will be developed in cooperation with Kenes international

10. General curricula in disability and rehabilitation	General curricula on disability and rehabilitation in medical education have been developed	The ISPRM curricula for undergraduate education and for specialist training will be published by the educational committee. Thereafter actions will be taken to implement these at national levels. They will be integrated into the next collaboration plan with WHO
11. Fighting discrimination	Implementation of the UN Convention on the rights of people with disabilities	The respective sub-committee of the WHO liaison committee will be merged with the WHO implementation subcommittee in order to achieve synergetic effects ISPRM will develop a concept to observe UN activities and analyse its impact for medical rehabilitation A concept to increase the number of people with disabilities in medical schools and specialist training centres will be developed until 2013
12. Implementation of the ICF in rehabilitation	1. Review the process of implementation of the ICF in rehabilitation practice 2. Define functional properties of the most relevant health conditions in rehabilitation 3. Develop ICF based assessment tools for functioning and disability	1. A systematic review on the implementation of the ICF in clinical practice has been published in 2012 2. In close cooperation with WHO the ICF Implementation Subcommittee is working on a list of functional properties of the 100 most frequent health conditions in rehabilitation 2. A project to develop a ICF-based mobility assessment too has been started. Its results will be published in 2015
13. Contribution to WHO guidelines and develop best practice models for implementation	Developing concepts for community-delivered rehabilitation services as published by WHO	A new subcommittee within the WHO liaison committee will be established in mid 2013. It shall develop criteria and concepts to improve rehabilitation service delivery in the community. A special focus of this work will deal with the specific situation of low and middle income countries
14. Development of best practice models for rehabilitation of patients with specific health conditions	ISPRM will stepwise develop best-practice guidelines for health conditions with high prevalence in rehabilitation. This includes the definition of functional syndromes	The newly founded Clinical Science Committee will develop a strategic plan and a list of priorities Regular information about existing guidelines will be disseminated e.g. using the MediGrip® App
15. Strengthening medical rehabilitation through unifying taxonomy	1. Position papers on conceptual descriptions of the rehabilitation strategy and PRM 2. Discussion paper on rehabilitation services within health services matrix	1. Conceptual descriptions of rehabilitation as a health strategy and of PRM have been published and adopted by ISPRM in November 2012 after intense discussion. Explanation of these descriptions and use cases will be published 2. A framework for the description of rehabilitation services is under development and will be published for further discussion in a series of conceptual papers until the end of 2013 by the WHO-Liaison sub-committee on Strengthening Medical Rehabilitation

PRM: Physical and Rehabilitation Medicine; WHO-DAR: World Health Organisation Disability and Rehabilitation team; ESPRM: European Society for Physical and Rehabilitation Medicine; UEMS: European Union of Medical Specialists; EARM: European Academy for Rehabilitation Medicine; AMLAR: Latin American Medical Association for Rehabilitation; AOSPRM: Asia-Oceanian Society for Physical and Rehabilitation Medicine; PAPRM: Pan Arab Association for Physical and Rehabilitation Medicine; PCO: Professional Congress Organizer; CBR: Community Based Rehabilitation; ICF: International Classification of Functioning, Disability and Health; UN: United Nations.

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