



PRM in Europe

ESPRM

Physiatry is in Europe not a very old Discipline but precisely for this reason it has vigorous young roots. Its taproot – which as always in Medicine is part science, part research, a craftsman-like experience in the field, much inspection of human relationships with people and critical reflection – highlights the duality of the “Physical” component, meaning attention to the whole physical environmental context which interacts positively or negatively with the Person and his problems, and the “Rehabilitative” component, meaning the finalised aim of every intervention. (3,14).

The two components of this duality combine ever better, strengthening each other in research and in clinical practice. Precisely in the current transformation of health care demands they are showing their maximum potential and their enormous intrinsic value.

A traditional medical intervention concentrates only on the disease process. In contrast the clinical and research attitude of Physiatry never separates disease processes from the individual as a whole and his active and passive relations with his surrounding context; indeed the physiatric approach is based constantly on the awareness that the determining factor is precisely this relation and not the isolated biological conditions.

In a traditional medical intervention the evaluations and prognosis are based on an analytic separation of the single bio-pathological factors followed by their rational integration into an overall sum; in contrast, a primarily rehabilitative view leads to considering the whole (functional, emotional, motivational and behavioural) as the *primum movens* focusing the parameters for determining the modality, limits and aims of the care only on this. Since health status is the result of a complex and large number of different factors, the therapeutic pathway to reach the maximum possible levels of recovery and maintenance must be equally complex, synergic and multifactorial, despite the fact that sometimes the single pathological conditions have a serious and chronically progressive course, or even a dismal prognosis.

The central point (a tool and in the same time a goal) for PRM is the Individual Rehabilitation Plan which collects and distils all the previously mentioned concepts, and concretely expresses the true epicentric status that the Person must hold in all stages and in all interventions. The Individual Rehabilitation Plan represents the possible pathway for reaching an optimal state of well-being, participation and health; it combines the skills and duties of the various members of the Team (which is the indispensable Unit for rehabilitation care) and the different treatment settings and structures in the different periods of this process. The Individual Rehabilitation Plan defines, recapitulates and verifies the entire content of this tangible pathway towards recovery of as much autonomy as possible; it must, above all, be experienced and agreed by the Person, but it must also be based on precise and validated scientific elements. (4,7).

These cohesive elements, both on an individual level and at a population level, must represent the meeting point between scientific evidence and epidemiological evidence: a plan of Indicators of Health in different Countries (e.g. the European Community as a whole), a plan

that could, therefore, represent a well-founded and transparent list of the priorities of possible interventions in relation to their efficacy is undoubtedly a fundamental aim for us all.

From the point of view of health care there is a need for the diagnostic, prognostic and therapeutic evaluation to have a unifying capacity, collecting together all the different elements in order to best understand the way in which the different pathologies, biological, psychic, emotional, relational, and affective problems, the socio-cultural conditions and context can interfere with the Person's functions, potential and desire to recover Activity and Health.

PRM now is an independent medical specialty in all European countries, except Denmark and Malta but its name and focus varies somewhat according to different national traditions and laws. Training usually lasts for between four and six years depending on the country (UEMS Charter on Training, EC Directive 93/16/EEC, 5 April 1993). Specialists in PRM have freedom of mobility across UEMS member states, but require certification from their national training authorities. (10,13). Fields of competence are all aspects of Disability and limitation of Activity, caused by any pathology, in every age of patients. PRM Doctor is the only competent to offer a complete, efficacy/effectiveness care covering all aspects of problems of Disabled People, involving also family and care-givers and in relation to the contextual, relational, community factors.

The PRM specialist either performs the intervention aiming to solve the given problems or another team member may do so. In other settings the PRM-specialist will prescribe the therapy. Interventions include:

1. Medical interventions

- Medication aiming at restoration or improvement of body structures and/or function, e.g. pain therapy, inflammation therapy, regulation of muscle tone, improvement of cognition, improvement of physical performance, treatment of depression;
- Practical procedures, including injections and other techniques of drug administration;
- Assessment and review of interventions;
- Prognostication;

2. Physical Treatments

- Manual therapy techniques for reversible stiff joints and related soft tissue dysfunctions;
- Kinesiotherapy and exercise therapy;
- Electrotherapy;
- Others including ultrasound, heat and cold applications, phototherapy (e.g. Laser therapy), hydrotherapy and balneotherapy, diathermy, massage therapy and lymph therapy (manual lymphatic drainage);

3. Occupational therapy to a) analyse activities, such as those of daily living and occupation, support impaired body structures (e.g. splints), b) teach the patient skills to overcome barriers to activity of daily living (e.g. adjusting private facilities), c) train in the presence of impaired function and cognition and d) enhance motivation;

4. Speech & language therapy within the framework of complex specialized rehabilitation programmes;

5. Dysphagia management;

6. Neuropsychological interventions;

7. Psychological assessment and interventions, including counselling;
8. Nutritional therapy;
9. Disability equipment, assistive technology, prosthetics, orthotics, technical supports and aids;
10. Patient education;
11. Rehabilitation nursing.

Nowadays all these contents are really into the cultural basis and scientific knowledges , but not so clearly into practical and daily activity of every PRM Doctor in Europe: also the education curriculum in some Countries is not so common and commonly complete in every Countries. Unfortunately in few Countries remain the old and negative view to “divide” organs and apparatus, or ages and pathologies, so wasting the efficacy of PRM scientific and clinical approach. In some National Health Services (in southern and mediterranean part of Europe as Portugal, Spain, Italy, France, Grece but also in Belgium and Netherlands) these big errors (and horrors) are avoided since many years ago, and these National PRM Societies was the first in Europe. But now the development of researches, the necessity to demonstrate efficacy, scientific basis and evidences, the necessity to demonstrate results for people and for Community (also in relation to the increasing financial investments) according to Health, Authonomy and Participation, are supporting strongly our point of view in every country and situation. For example neurological rehabilitation (including Stroke, SCI or Brain Injury), cardiac or pulmonar rehabilitation, cancer or bladder rehabilitation are simply accepted only as parts in a global and synergetic approach and service defending and enhancing the unity of the disabled people.

In fact the most important point is the necessity to measure the results of any interventions and cares: only by this global approach and this unitary management is possible to evaluate the relationships between treatments (and costs) and effects for patients and community.