Archives of ISPRM 2026;1(x):i-ix

Original Article

OPEN ACCESS

Strengthening Physical and Rehabilitation Medicine (PRM) in small health systems: Identity, training and system integration in Malta

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Abstract

Objectives: Small countries face distinctive challenges when developing Physical and Rehabilitation Medicine (PRM): limited specialist numbers, constrained academic infrastructure and marginalization in national health policy. Malta, one of the smallest European states, is undergoing substantial reforms to strengthen PRM locally. Providing a comprehensive analysis of Malta's PRM development, while deriving lessons relevant to other small states facing similar pressures. The report covers professional identity, governance, workforce, clinical practice, training, and academic alignment.

Materials and methods: Synthesis of international and European rehabilitation frameworks, academic initiatives (such as the European Organization of University PRM, UniPRM), and peer-reviewed literature on PRM policy and small-country system development. Subsequently, Malta's PRM activity timelines, educational strategies and specialist training frameworks were reviewed.

Results: Malta has implemented a wide range of reforms in the last three years from a shift towards the internationally recognized term of PRM totargeted public awareness campaigns on rehabilitation and disability empowerment. On a more concrete level one can find the introduction of a new undergraduate PRM teaching schedule, the introduction of evidence-based clinical practice guidelines, and the creation of a competency-based national PRM training program. These actions have increased visibility, improved service quality, and attracted new trainees. However, significant structural gaps persist: the absence of PRM clinical and academic departments, limited leadership representation, and a critically small workforce.

Conclusion: Malta demonstrates that small states can make meaningful progress in PRM through sustained, coordinated reform across identity building, training, clinical governance, and academic alignment. Continued progress now requires embedding PRM within clinical and academic structures, strengthening governance representation, and consolidating the workforce to ensure PRM fulfils its essential role in the Rehabilitation 2030 agenda.

Keywords: Awareness, education, prm, rehabilitation, small.

The global burden of disability continues to rise at a pace that challenges existing health systems. Population ageing, increased survival following acute illness, and the escalating prevalence of non-communicable diseases (NCDs) have created an unprecedented demand for rehabilitation services. The World Health Organization (WHO) estimates that one in three

Submitted: January 28, 2026
Accepted: March 19, 2026
Published: May 15, 2026

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Doi: https://doi.org/10.5606/archisprm.2026.3

Citation:
Anastasi AA, Vella CM. Strengthening Physical and Rehabilitation Medicine (PRM) in small health systems: Identity, training and system integration in Malta. Arch ISPRM 2026;1(x):i-ix. https://doi.org/10.5606/archisprm.2026.3.

individuals will require rehabilitation at some point in their lives, emphasizing the centrality of rehabilitation in modern health systems.[1] This need is reflected in the WHO Rehabilitation 2030 initiative and the 2023 WHA76.6 resolution, which articulate a global mandate to develop the rehabilitation workforce, expand service delivery, strengthen governance structures, and integrate rehabilitation across the continuum of care.[2]

In parallel, the conceptual framework of health measurement has evolved. The explicit positioning of "functioning" as the third health indicator-alongside mortality and morbidity-has strengthened the theoretical and practical foundations of Physical and Rehabilitation Medicine (PRM).[3] This emphasizes the prioritization of human functions such as mobility, communication and independence in activities of daily living as a measure of good health and successful medical intervention and outcome, beyond mere survival or disease-burden. Visually put, functioning and disability can be thought of as two polar opposites of the same spectrum, where rehabilitation aims to optimize functioning by reducing disability through a myriad of strategies and technologies available. This shift highlights the vital role of PRM physicians in leading rehabilitation services and reforms, and ensuring functioning becomes a pivotal consideration when looking into any healthcare outcome.

On the other hand, implementing these global priorities is particularly challenging in small countries (often defined as populations of 1.5 millions or less). These systems often operate with minimal human and infrastructural resources, constrained (or lacking) tertiary centers and clinical departments, and small academic structures and professional societies. Malta, a European Union (EU) member state with just over half a million inhabitants within a 316-square kilometers area of land, exemplifies these structural constraints while also demonstrating the opportunities inherent in small, centralized health systems.[4] Over the past several years, Malta has undertaken a series of targeted reforms aimed at consolidating PRM as a distinct specialty, elevating the role of rehabilitation, and aligning its services with European standards.

In this article, we provide an in-depth analysis of PRM development in Malta, discussing achievements and ongoing weaknesses, and highlighting lessons relevant to other small states aiming to strengthen rehabilitation capacity in line with Rehabilitation 2030.

MATERIALS AND METHODS

This paper adopts a structured policy case-study methodology with narrative synthesis. Key international frameworks, including WHO Rehabilitation 2030 and the WHA76.6 resolution, were reviewed to identify global priorities for rehabilitation system strengthening.[1,2] European references, particularly the European PRM Bodies Alliance White Book on PRM in Europe[5] and the 2023 European Training Requirements (ETRs),[6] served as benchmarks for best practice in specialist development, service organization, and academic alignment, as did similar literature on PRM integration in health systems.[7] Academic developments, including the founding framework of the European Organization of University Physical and Rehabilitation Medicine (UniPRM), provided additional context on emerging European academic priorities.[8]

To create a detailed picture of Malta's trajectory, national-level documentation was reviewed, including the Maltese Specialist Accreditation Committee's PRM Framework (2025),[9] public communications of the Maltese Society of PRM (MSPRM), national audits, WHO country profiles,[4] and locally conducted research. The narrative sections were enriched by data on similar efforts of specialty expansion abroad.[10]

RESULTS

Malta's Context, Rationale for PRM Development, and Workforce

Malta's health system is highly centralized, with the majority of healthcare being government-owned and free for taxpayers. The primary resources go into one single main general hospital and a single rehabilitation hospital shared with geriatric services. This centralization has its advantages when it comes to standardization and implementation of new

policies and strategies, but also makes the system vulnerable to collapse. Particularly concerning is that Malta has only two practicing PRM specialists with no dedicated clinical department, a single university lacking a dedicated PRM academic unit, and limited research capacity. As disability and chronic disease rates rise, particularly with the demographic shift toward an ageing population, demands on rehabilitation services are on an exponential rise, with limitations becoming increasingly pronounced.

The rationale for Malta's PRM development is therefore multifactorial. First, rehabilitation needs have exceeded available clinical capacity, requiring more structured, competency-based specialist presence and a matching workforce to maintain it. Second, the fragmented identity of PRM, partly owing to an Anglo-Saxon-influenced system, has limited involvement in national health policy decisions, contributing to underrecognition of the specialty. Third, academic anchoring is essential for sustaining guideline development, research output, and undergraduate teaching. Finally, alignment with European PRM standards helps ensure mobility, benchmarking, and external support networks, all of which are particularly important for small states.[1,5-7]

Population, Infrastructure, and Critical Workforce Shortage

Malta's population is rising significantly, reaching an estimated 574,250 by late 2024, a 1.9% annual increase, primarily driven by high net migration, particularly non-EU citizens, outweighing a decline in natural growth. This growth is part of a decade-long trend, with a nearly 29% rise from 2012-2022, making it the EU's fastest-growing, despite low fertility, due to an increasing share of foreign nationals in the population.[11]

As of late 2023/early 2024, over 27,000 people were registered with Malta's Commission for the Rights of Persons with Disability (CRPD), primarily with physical (21,000), intellectual (4,400), or psychosocial (3,700) disabilities.[12] This is most likely a gross under-estimation of the real burden of disability, with many elderly, frail or individuals within other vulnerable minority groups (such as illegal migrants) not registering with CRPD. In particular, Malta has one of the highest morbidity and mortality rates related to workplace accidents[13] and a significant amount of morbidity and mortality related to road traffic accidents and complications of NCDs such as diabetes and peripheral vascular disease.

At present, the PRM workforce in Malta remains critically small. As of 2025, only two active PRM specialists and one registered but inactive specialist serve the entire country, equating to approximately 0.37 PRM physicians per 100,000 inhabitants. This is markedly below the European average of 4 PRM physicians per 100,000 inhabitants, based on European workforce analyses showing a specialist pool of approximately 20,000 PRM physicians and more than 3,000 trainees.[10] The Malta's ratio is, therefore, an order of magnitude below the benchmark. The reasons are historical, structural, and cultural: the Anglo-Saxon model adopted by Malta mirrors the low PRM presence of the United Kingdom (UK) itself, where PRM/rehabilitation medicine similarly remains a small, underrepresented specialty.[10] Nevertheless, a recent wave of academic and clinical momentum has also been observed in the UK, led by the British Society of PRM. This has led to a three-fold increase in their members in only three years, and this, in part, has been one of the main inspirations of Malta's current drive for expansion, as well.[14]

Strategies and Reforms for Strengthening PRM

Efforts to strengthen PRM in Malta can be categorized into four main pillars:

- Strengthening professional identity, which aligns with one of the main missions of the International Society of Physical and Rehabilitation Medicine (ISPRM)
- Public awareness and knowledge translation, which aligns with the goals of the European Society of Physical and Rehabilitation Medicine (ESPRM)
- Enhancing post-graduate training and standards of practice, which align with the role of the UEMS-PRM Section and Board
- Boosting research and academia, aligning closely with the mantra of UniPRM

All four pillars, along with other small strategies, have been pivotal parts of the drive towards local reform in Malta over the last few years and will be presented as a case study for other small health systems and countries aiming to strengthen their local PRM field.

Strengthening Professional Identity Through Nomenclature

The PRM's identity is strongly influenced by its name. International literature consistently demonstrates that specialty nomenclature plays a central role in public understanding, professional identity, policymaking, and intersectoral collaboration, with countries adopting the term PRM exhibiting a relatively larger workforce within the specialty.[10,14,15] While Malta's law still limits the full adoption of the term PRM within the official registry, Malta has begun to adopt the term PRM across other platforms, including electronic patient records, letterheads, teaching, and many other professional and public contexts. The society also underwent a rebranding effort in 2023 to align more closely with European and global terminology, moving from the Malta Physical and Rehabilitation Medicine Association (MPRMA) to the Maltese Society of Physical and Rehabilitation Medicine (MSPRM).

These steps helped clarify the medical scope of PRM and differentiate PRM physicians from non-medical rehabilitation providers. The legal specialty title in Malta remains "rehabilitation medicine," reflecting residual Anglo-Saxon influence. Nevertheless, the new national training program, entitled A Physical & Rehabilitation Medicine (PRM) Framework, which also describes itself as a Rehabilitation Medicine Training Program approved by the Specialist Accreditation Committee (SAC), Malta, signals a strategic intention to ultimately achieve legal adoption of the internationally recognized PRM title.

Public Awareness Campaign: Enhancing Visibility

Public engagement has been essential in elevating the visibility of PRM. Over the past two years, the MSPRM has been increasingly active in public-facing initiatives. These efforts included participation in Science in the City festivals, radio interviews targeting general audiences, themed workshops addressing stroke and amputee care, and focused collaborations with organizations such as the Malta Paralympic Committee and the Amputees for Amputees support group. Additionally, the society launched the first edition of its public-facing newsletter, Physical, in 2025.[16] These activities have served to increase recognition of PRM and situate it within broader discussions of disability, health, and inclusion.

Within the medical field itself, efforts to explore perceptions and expectations related to rehabilitation services have also been underway, with a recent publication reflecting results of a survey done internally within the main rehabilitation hospital[17] and one underway looking into perception of PRM amongst medical students.

Undergraduate Teaching: Embedding PRM Early

In 2022, Malta introduced structured PRM teaching into the undergraduate medical curriculum. First- and second-year medical students now receive regular lectures covering fundamental principles of PRM, including the International Classification of Functioning, Disability and Health (ICF).[18] These lectures have been reinforced through hands-on workshops in musculoskeletal ultrasound, prosthetics, and disability awareness. Increasingly, students have been engaging in voluntary experiences within inpatient rehabilitation wards, creating early exposure to disability, functioning, and multidisciplinary care. This early visibility is crucial in small systems, where specialty awareness significantly influences career interest.

This formal teaching has also been mirrored by close collaboration with the Malta Medical Students' Association, which has organized joint events ranging from prosthetics workshops to disability empowerment campaigns and games nights for inpatients undergoing rehab at the main rehabilitation hospital. This allowed for both heightened exposure to the PRM specialties and a more practical application of concepts related to disability and rehabilitation.

International Partnerships and Academic Alignment

Recognizing the limitations of a small academic base, Malta has actively cultivated international partnerships to strengthen training, research, and academic input. Malta's representation on the UEMS-PRM executive committee, as well as continued involvement in the European Society of PRM (ESPRM) and the Mediterranean Forum of PRM (MFPRM), has positioned the country within influential European bodies despite its small size.

The alliance with the British Society of Physical and Rehabilitation Medicine (BSPRM) has been particularly valuable, providing foreign annual review of competence progression (ARCP) examiners, continuing professional development resources, and access to training opportunities across more than 30 UK rehabilitation centers.

Most recently, Malta has joined the efforts of the newly established European Organization of University Physical and Rehabilitation Medicine (UniPRM), with active representation on the founding council and support for strengthening academic PRM as a means to enhance the specialty's recognition and workforce.[8]

A new local Training Program for PRM Specialization: Structure and Significance

The national curriculum for specialist training in PRM, launched in 2025, represents a transformative development in Malta's PRM landscape. The program is competency-based and explicitly aligned with the UEMS-PRM ETR 2023.[10] Although the legal name of the specialty has not yet changed, naming the program the PRM Framework reflects the firm intention to modernize national terminology.

The curriculum outlines a four-year training program across the full spectrum of PRM practice, including rehabilitation for people with nervous system and musculoskeletal disorders, for medicine for individuals with disabilities, and integrative rehabilitation science. It also includes structured core rotations in neurology, orthopedics, geriatrics, internal medicine, intensive care, and pain medicine. Advanced competencies, such as ultrasound-guided interventions, spasticity management, leadership, and logbook documentation, are incorporated. A defining feature of the program is the requirement for a minimum of 18 months of international training across at least two different countries, ensuring equitable exposure despite local limitations.

Annual research and quality improvement projects are mandatory, and trainees must complete successfully the European PRM Board Examination. Assessment processes include monthly and annual reports and participation by foreign examiners, ensuring objectivity and alignment with European standards.

The program not only provides structure to specialist development, but also acts as a manifesto for advancing PRM as a recognized and essential medical specialty in Malta.

Evidence-Based Practice and Research Development

Several evidence-based practice initiatives have reinforced PRM's clinical footprint in Malta. Notably, the development of national Clinical Practice Guidelines on Autonomic Dysreflexia and Neuropathic Pain Management, published on the acute hospital servers, represents Malta's first PRM-led guideline development and an essential milestone in clinical governance.[16] On a global level the Cochrane Thematic Group: Cochrane Rehabilitation, Functioning, and Disability[19] has been instrumental in cementing the concept of evidence-based practice in PRM and has been a major inspiration to local initiatives in this regard, as well.

Clinically, the small team of PRM physicians have ensured consistent and regular use of ultrasonography for bedside MSK diagnostics and routine ultrasound-guided interventions such as botulinum toxin injections, intra-articular injections and nerve blocks, something which was not common before, and which is seldom seen in other specialties locally, where botulinum toxin injection and intra-articular injections in particular are done using the manual method approach.

Digital rehabilitation prescriptions and progress-tracking systems have improved interdisciplinary team communication, goal setting, and outcome monitoring. Local research

continues to inform service design, including a pre-pandemic study on inpatient rehabilitation referral processes[20] and an ongoing longitudinal follow-up study exploring long-term rehabilitation outcomes two to three years post-discharge.

These developments mirror broader European academic priorities and highlight the importance of anchoring PRM not only clinically, but also academically a vision strongly advocated by UniPRM.[8]

Remaining Structural Shortcomings

Despite significant progress, Malta continues to face major structural barriers that limit the full realization of PRM's potential.[21] The most pressing challenges include the absence of a dedicated PRM clinical department and the lack of an academic department or chair. Without these structures, PRM remains administratively fragmented, limiting the specialty's ability to shape service design, training, research, and national policy.

Leadership representation also remains inadequate. Physical and Rehabilitation Medicine is often overshadowed by larger specialties such as geriatrics, neurology and orthopedics, in discussions of national strategy, rehabilitation system design, chronic disease management, and long-term care planning. Workforce fragility compounds these challenges and the system remains vulnerable to burnout, turnover, or service disruption.

Finally, operational constraints persist within rehabilitation settings. These include limited allied health staffing, insufficient therapy spaces, outdated equipment, and constrained outpatient capacity; i.e., issues documented across multiple local audits.[17,20] Currently, the intensive rehabilitation service remains limited to 60 beds across two inpatient wards, with only a few outpatient clinics led by physiotherapists and occupational therapists. These reside within the old hospital of Malta, with plans for relocation being present for a number of years. Within high intensity rehab wards, under the leadership of two PRM specialists, work a full complement of nurses and allied health professionals. More specifically one usually finds three occupational therapists and five physiotherapists dedicated to each 30-bed ward, one social worker, pharmacist and junior doctor per ward on rotation, three speech therapists in the neurorehabilitation ward and a number of other professionals such as psychologists, podologists, tissue viability nurses and dieticians shared with a larger 10 ward geriatric/rehab hospital who perform reviews as necessary.

DISCUSSION

Interpreting the Reform Success: The Small State Paradox

Malta's experience demonstrates the dual nature of small, centralized systems in implementing global health policy. The introduction of the national PRM training program and the strategic shift in nomenclature were made possible by the advantages of centralization. Once key stakeholders were informed, system-wide reforms could be implemented relatively rapidly and uniformly. This stands in contrast to large, decentralized systems where regulatory alignment can take years.

However, this success is fragile. The current workforce ratio of 0.37 PRM physicians per 100,000, an order of magnitude below the European benchmark of 4.0, means the entire service, training, and academic burden rests upon a handful of specialists. This structural fragility is the 'Small State Paradox': rapid policy implementation is possible, but its sustainability is severely threatened by minimal human resource redundancy. The specialty remains institutionally vulnerable; the loss of a single key leader could jeopardize the entire training scheme and service delivery.

It is worth noting that the density of PRM specialists across Europe remains significantly heterogeneous and is not always directly related to a country's size. To illustrate, while the UK reported one of the lowest ratios (0.24 per 100,000), Lithuania reported the highest, at 13.46 per 100,000 inhabitants.[5] As noted earlier, substantial reforms have taken place in several countries since then, and it would be interesting to see whether these have translated into meaningful changes in workforce capacity and cross-European distribution.

Necessity of Institutionalization for Sustainability

The next phase of PRM development must transition from programmatic growth to institutional embedding. The achievements in training and identity building have created momentum, but this momentum cannot sustain itself without a formal structure. The current absence of a PRM Clinical Directorate or a University Chair means the specialty lacks the formal authority required to influence national resource allocation, long-term policy formulation, and multidisciplinary governance. Without this institutional representation, PRM risks remaining an "add-on" service rather than being recognized as an essential, cross-cutting medical specialty, as envisioned by the WHO Rehabilitation 2030 agenda.

This challenge is not unique to small states and island health systems, but has also been observed in middle-income countries, such as Nepal and Georgia, where PRM and rehabilitation services are still in the process of integration.[22] In response to such variability, the WHO developed the Systematic Assessment of Rehabilitation Situation (STARS), a standardized health system assessment tool designed to generate structured, comparable data on how rehabilitation is embedded within national health systems.

Countries with poor governance structures for rehabilitation consistently demonstrate a limitation in policy influence leading to fragmented implementation, despite increasing awareness and recognized need. In this context, the Maltese experience reflects a broader international pattern: without institutional anchoring, gains in training and professional identity remain of limited impact. Formal embedding can on the other hand provide the structural legitimacy required for long-term sustainability and system-wide integration.

International Alignment and Future Workforce Stability

The proactive alignment of the national training program with the UEMS-PRM ETR 2023 is a critical strategy for mitigating local structural limitations. The mandatory international training component not only ensures high-quality competency development but also cultivates vital external professional and academic networks. This approach is particularly important for small states, as it provides external validation and structured knowledge exchange that can partially substitute for a large internal academic base. Looking ahead, collaboration with UniPRM and the consequent strengthening of the academic footprint of PRM within university teaching and research are expected to foster more organic and sustainable workforce growth.[23] By enhancing the academic credibility and visibility of the specialty, PRM may increasingly attract high-performing medical graduates who have traditionally been drawn to more competitive, popular disciplines, leading to a broadening of the talent pipeline and reinforcing the specialty's long-term development.

Conclusions and Recommendations

In conclusion, Malta's journey demonstrates that small states, despite severe structural limitations, can make meaningful and rapid progress in PRM. Coordinating reforms across identity, training, and clinical practice are key strategies in achieving this. The introduction of the national PRM training program has been a pivotal milestone, successfully attracting a new generation of specialists and creating immediate momentum for system improvement. However, the progress remains vulnerable due to the lack of dedicated institutional structures. To consolidate achievements and move beyond the current crisis-level workforce ratio, Malta—and other small systems—must prioritize institutional embedding of the specialty.

Key Recommendations for Continued PRM Strengthening:

1. **Institutionalize PRM as a Core Medical Specialty**

Embedding PRM within national health policy ensures PRM representation, through a dedicated clinical department or director, within leadership and service planning frameworks. This enables formal recognition of PRM as the medical authority on disability, functioning, and rehabilitation, in line with ISPRM's mission, and supports the sustainable implementation of policies that are not vulnerable to reliance on single key individuals.

2. Strengthen Public Awareness and Policy-Level Understanding of PRM

Targeted and sustained knowledge translation efforts are required to improve understanding of PRM's scope and system-level value among policymakers, healthcare professionals, and the public, acknowledging that visibility in small systems directly influences prioritization and resource allocation (ESPRM alignment).

3. Align Postgraduate Training with European Standards

National PRM training programs should be formally aligned with UEMS-PRM standards through structured curricula, external benchmarking, and mandatory international exposure, thereby safeguarding training quality and professional credibility in small and resource-constrained systems.

4. Strengthen Academic Capacity to Attract Forward-Thinking Clinicians and Researchers

Enhancing PRM's presence within university education and academic research, through initiatives such as UniPRM, strengthens the specialty's academic credibility and legitimacy, attracts research-oriented and innovative clinicians, and promotes further investment in PRM research and higher standards of care.

These structural steps will enable PRM to transition from a successful, specialized initiative to an essential, resilient, and fully integrated component of the national health system, fulfilling its obligation to meet the rising global demand for rehabilitation and the goals of Rehabilitation 2030.

Declaration of Conflicting Interests

The authors declare that there are no conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Author Contributions

A.A.A.: Conceptualisation, literature search and first draft; C.M.V.: Conceptualisation, local data analysis and discussion, finalisation of manuscript.

Data Availability

The datasets generated and/or analyzed during the current study are available from the corresponding author on reasonable request.

AI Disclosure

The authors declare that artificial intelligence (AI) tools were not used, or were used solely for language editing, and had no role in data analysis, interpretation, or the formulation of conclusions. All scientific content, data interpretation, and conclusions are the sole responsibility of the authors. The authors further confirm that AI tools were not used to generate, fabricate, or 'hallucinate' references, and that all references have been carefully verified for accuracy.

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