Big Servings in the Lone Star State

Keith Chan found that Texas doesn’t do anything in half measures

A ustin, Texas bills itself as the “Live Music Capital of the World”. Famous residents include country music legend Willie Nelson, cycling superstar Lance Armstrong, and the 1.5 million Mexican free-tailed bats that live under one of the city’s main bridges. Possibly of greater interest to AFRM Fellows, it also played host to the 2009 AAPM&R conference.

In October 2009 a small group of Australian and New Zealand Fellows journeyed across the Pacific to Austin, Texas to attend the 70th American Academy of Physical Medicine and Rehabilitation (AAPM&R) Annual Assembly, the first time this conference has been held in the Texas state capital. I arrived a day prior to the official conference and made a last minute decision to attend the preconference course on spasticity and dystonia management. This turned out to be one of the educational highlights of my trip. There were interesting lectures on neurotoxin and phenol injections, intrathecal baclofen management, and physical modalities/orthotic use that were more than good enough to keep the jet-lag Zs away. Small group workshops by experienced rehabilitation physicians and neurologists allowed practical demonstrations of the above topics, including fascinating use of ultrasound guidance for neurotoxin injection.

Later that evening I took a quick tour of the preconference job fair, which mainly attracts graduating American rehabilitation physicians. Judging from the number of booths set up by academic departments and large multispecialty clinics, there appeared to be a healthy on-going demand for rehabilitation physicians despite the continuing uncertainties associated with health care reform in America.

The actual conference educational program was organised into the usual six primary parallel tracks: musculoskeletal medicine, neurological rehabilitation, practice management and leadership, rehabilitation topics, spine/spinal cord injury, and a program specially catering to trainees. There were also secondary tracks in brain injury, electrodiagnostic medicine, geriatrics, pain rehabilitation, paediatrics and spinal cord injury. This busy schedule started at 7.30am and often did not finish until well after 5pm on most days.

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**Have your say!**

We welcome letters to the Editor. You must provide your full name and address for verification. The views expressed in any letter published are those of the individual writer and not necessarily endorsed by the Faculty.

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**Rhaïa**

March 2010

The Australasian Faculty of Rehabilitation Medicine

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**MISSION AND CONTENT**

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Some while ago, I wrote about change management and work with our patients as Consultants in Rehabilitation Medicine.

Very recently I had the experience of moving an elderly relative into a self-care unit. With slowly progressing visual impairment and less steady balance, the time had come to move from a small apartment on the side of a hill north of Sydney Harbour with a 20 degree slope in the access to the home, to a self-care unit with level access in an aged care complex. Without the move, I feared a fall on the steep 1930s concrete driveway, with consequent fractures and hospital stay. Despite my belief in the efficacy of our services, primary prevention is best of all!

It took several weekends of work by members of our family to pack and sort many years of her accumulated books, clothes and possessions, with all the expected apprehension from all of us, elderly person and baby-boomers alike, about living in the new environment. It is very different indeed to be part of the process as a family member than as the clinician initiating things.

Moving day arrived and was overcast, grey and relatively cool. The task of moving and initial unpacking took 12 hours. For the next weeks, we needed to provide support and frequent visits, to remind where things were to be found in the new unit, and iron out some early problems with using a different kitchen (no gas, all electric) and the bathroom facilities.

But life has quickly settled into routine – thankfully, the new unit is within the same suburb, about a kilometre away from the old apartment. Her GP is no longer a bus ride away, but just two minutes’ walk. The favourite hairdresser is now to be found across the street, and the main shops are less than five minutes’ away.

Although services are closer, the need to do more local walking (instead of riding a bus) has produced a subjective feeling of better energy levels. Best of all, the experience of eating a full lunch each day (with choice of menu) and chattering together with a group of other older people, some of whom are friends of many years’ standing, has produced a visible and continuing improvement in energy and mood from the very first day in the new setting.

With careful change management, transition into aged care living can be a very positive experience.

Andrew Cole
Difficult choices had to be made in selecting the lectures to attend. One could only be in one place at a time! Thankfully, the selection process was made less painful by the knowledge that I could purchase the entire conference proceedings on DVD afterwards. I decided to attend lectures in my special interest areas of musculoskeletal, pain and electrodiagnostic medicine, and neurological rehabilitation. There has been explosive growth of interest in ultrasound use in rehabilitation/musculoskeletal practice in the United States and this was reflected in the educational program, poster presentations and, last but not least, in the technical exhibition hall.

The technical exhibition hall was a huge attraction by itself, with plentiful hall space devoted to marketing booths & exhibits. I must confess I enjoyed wandering through the technical exhibit booths with their enticing offerings of injection simulators, ultrasound equipment with model demonstrations, unfamiliar non-PBS listed medicines, and a wide variety of rehabilitation, electrodiagnostic & pain management equipment. There was even a booth offering upper body massages to refresh attendees who might have developed exhibition hall muscle pain syndrome. The intellectual aspects were not neglected, with several book stalls providing opportunities to review the latest rehabilitation textbooks and make advantageous use of the strong Australian dollar.

Many US PM&R departments and state medical societies held their alumni reunion and meeting sessions in the evenings. For other conference attendees, there was 6th Street, the main downtown entertainment and dining area. It did not disappoint in its choices of Mexican, BBQ and American food, typically served in diet-defeating Texas sized portions, and live music venues.

This year, for the first time, there was a dedicated session just for poster presentations. Besides exposure to numerous case reports and early research findings, I found the poster session to be a wonderful and under-rated opportunity to meet and chat with rehabilitation physicians from all over the world. You start discussing the poster topic and, before you know it, you find yourself exchanging stories and email addresses.

Whether you are an experienced rehabilitation physician, a new Fellow, generalist or subspecialist or trainee, the AAPM&R conference offers something for everyone (albeit with a North American flavour). It's a great venue to update, challenge or feel reassured about one's practice and knowledge, and to meet with your North American, Australian and international colleagues. I highly recommend attending future AAPM&R conferences for these unique opportunities.

Keith Chan
Selling Rehabilitation

Some three years ago the Faculty arranged for a professional research company, Taverner Research, to undertake research with Fellows, trainees and external stakeholders. The results have been published previously in Rhaïa and have informed the Executive in its efforts to enhance the status of our specialty. It was, one supposes, no real surprise that Fellows and trainees thought the specialty was unknown, but the idea that we were a bunch of quite nice “cardigan wearers” (government departmental stakeholder) perhaps stung some of us considerably. Since then things have improved, but there is a long way to go.

One of our key issues is for all Fellows and trainees to take responsibility for selling our message, and this means knowing what our message is.

How do you explain to someone what you do, in a lift?

This depends partly on the audience, and for the general public, our many meetings with Fellows, media consultants, journalists, other physicians, and other members of our professional rehabilitation teams have given rise to a series of ‘one liners’ like these:

- **Rehabilitation Teams do not save lives, but we do make the saved life worth living.**
- **Rehabilitation is the “what happens next” after a person suffers a disabling accident or illness.**
- **Restoring people to their roles in society doesn’t happen by magic, it takes all the members of the Rehabilitation Team, including the patient.**

For politicians and bureaucrats, on the other hand, effective messages seem to be those which focus on the effects of rehabilitation on the wider health system:

- **Rehabilitation is the back door from the hospital system.**
- **Outcomes, including shorter length of stay, require the internationally proven amounts (intensity) of Therapy.**
- **Rehabilitation is the missing link between hospitals and the community (NHHRC Final Report, June 2009).**

An attractive, but as yet unproven message for the bureaucrats and politicians, may be:

*Rehabilitation is a Human Right enshrined in the UN Conventions on the Rights of Persons with Disabilities, Article 26, a convention ratified by both the Australian and New Zealand Governments.*

By the time you read this, the Executive, with key representatives of our multidisciplinary colleagues’ national associations, will have presented a combined National Rehabilitation Strategy to the Department of Health and Ageing in Canberra. This is based on the strategy that we in the Faculty presented to the Department in 2008 and 2009, but with more hard evidence for our claims, as well as the additional force provided by our multidisciplinary colleagues. (We have agreed with these colleagues to institute an ‘alliance’ to further pursue advocacy, and to consider team-based training.)

One never knows how such representations will be received, but I have learnt that persistence pays. We have had excellent responses from Canberra in the last two years, but during that period it was apparent that little headway was being made in my home state of NSW, for example.

During 2009 the NSW State Branch Executive had several fairly dispiriting meetings with NSW Department of Health officials. Suddenly, however, in early December a far more encouraging meeting occurred, with, on this occasion, clear indications of an interest in the branch’s story. The Department promised a working party, with a range of specific objectives with regard to the development of rehabilitation services and, although it is very early days, this response was quite new and very encouraging, particularly in the light of previous responses. In this case, the branch did not need to be particularly persistent, because a good reception was received within a few meetings (I think for many of our issues we might need to persist for years).

I remain very gratified by the most encouraging aspect of working for the Faculty, that is the large number of people who work on committees, branches, and in so many other ways. Whenever I request help it is forthcoming and usually in abundance. Thank you for your support and assistance, and please keep on promoting our work with everyone you meet.

*Stephen Buckley*
Items of Interest

Policy & Advocacy Committee

The Faculty Policy and Advocacy Committee (FPAC) has not met since the last edition of Rhaïa. However, we have been busy!

Highlights include the finalisation of the draft Transition to Adult Services Position Statement following a very productive workshop in Brisbane attended by community, consumer and health stakeholders, both paediatric and adult. A/Prof Lyn Lee and Dr Kim McLennan are the main FPAC members driving what I hope will be a useful addition to the College position.

On behalf of the College, FPAC corresponded with the Federal Department of Families, Housing, Community Services and Indigenous Affairs providing comments on the Australian Government’s Harmonisation of Disability Parking Permit Schemes in Australia initiative.

I would draw the attention of the Faculty to the NHMRC’s development of a national clinical practice Guidelines in Development Register. The two guidelines selected for inclusion initially are not particularly relevant to this specialty, but the development of the Register itself will be of interest – you can access the Register at www.clinicalguidelines.gov.au/in-development.

FPAC through A/Prof Andrew Cole especially, provided comments to the NHMRC on their discussion paper, Ethical issues involved in the transitions to palliation and end of life care for people with chronic conditions: A Discussion Paper for patients, carers and health professionals.

Following the advocacy of Dr Matthew Gardiner, amendments have been made by the Roads and Traffic Authority (RTA) in NSW to the Mobility Parking Scheme (MPS) fitness to drive policy as it applies to temporary MPS cards. A ‘fitness to drive’ medical is no longer required for a first issue temporary MPS card or subsequent card if the previous temporary card expired. This removes an additional burden from those whose mobility or walking distance is only temporarily affected following procedures such as lower limb joint replacements. The ‘fitness to drive’ medical report does need to be completed if the applicant currently holds a temporary MPS card and is applying for a subsequent consecutive temporary MPS card where their tenure will be in excess of six consecutive months. Full details of the policy be found on the RTA website at: www.rta.nsw.gov.au/rulesregulations/mobilityparking/mobility_gpinfo.html

Through the College Policy and Advocacy Committee (CPAC), comments were given on the Faculty of Occupational and Environmental Medicine Position Statement on Helping People to Return to Work: using evidence for better outcomes. I draw the attention of all Fellows to this useful document.

Submissions on behalf of the College through CPAC were made to the Joint Standing Committee on Migration about the migration treatment of people with a disability.

FPAC wrote to the Parliamentary Secretary for Disabilities and Children’s Services, the Hon. Bill Shorten, and to the Hon. Anthony Albanese, Minister for Infrastructure, Transport, Regional Development and Local Government, on the recent policy of various airlines to require those who use a wheelchair to change into an airline chair on check in (rather than at the departure gate). This issue was strongly underlined by the Trainee Representative on FPAC, Dr Harry Eeman.

FPAC noted the media attention surrounding the US National Football League Policy on Concussions. We will develop a more rapid mechanism to enable the Faculty and College to provide media releases on current topics. I would be grateful if any Fellow or trainee who wishes to be involved in this aspect of the committee’s work would make contact with me through the Faculty Office.

The eHealth Expert Advisory Group (EAG) of CPAC is keen to survey the Fellowship to gather current information regarding use of technology, so that the EAG can more effectively advocate for physician’s needs in this field. It is proposed that a short set of different questions be formulated for NZ, as the two countries are at different stages in their eHealth adoption. The NZ survey is still being developed. This should be ready shortly and I urge all Fellows to complete the short questionnaire.

The FPAC in principle agrees with a Fellow’s request that it produce a position statement advocating for the liberalisation of the current S100 scheme with respect to Botulinum Toxin Type A. However, this will need to await the publication of the College Position Statement (which is being reviewed by the Faculty) on the use of Botulinum Toxin, which will be in concordance with the International Consensus Statement.

Kath McCarthy
Announcements

Photo competition

International Promotion of AFRM

In December last year, the International Affairs Committee announced the inauguration of a new $100 prize to be awarded annually to the Fellow (or trainee) who is photographed wearing the Faculty tie or scarf in the most exotic place.

Judging was undertaken by the Faculty’s International Affairs Committee and preference was given to photographs taken in a recognised international context or with the Fellow interacting with people who are obviously from other countries.

The International Affairs Committee is pleased to announce that the inaugural winner is Dr Malcolm Bowman for his two entries taken during the WFNR Spasticity Challenges and Solutions conference held in Barcelona in October 2009.

You can see all the photos in colour at the AFRM website

Faculty Committees
International Affairs Committee
Photographic Prize 2009.
**Dr Josephine Braid** is highly commended for her entries and will receive a consolation prize of a Faculty scarf.

**Dr Steven Faux** is to be congratulated for his creativity but is ineligible for the prize given that none of those in the photographs submitted are Faculty Fellows or trainees, and we are unaware of any accredited camel rehabilitation program in the Middle East.
Welcome to the second edition of Trainee Matters. Another Christmas has passed and we are back in the full swing of things, planning the year ahead.

Last month, I was given a (thankfully short-lived) shock when I received my Administration and Management Module essays back to be redrafted. To think, I had spent so many weekends in various libraries, collecting and reading the long list of references provided, and (or so I thought) compiled a thoughtful and concise summary of them in response to the questions. For me, a typical type-A personality who always wants to do the best she can, having work sent back and labelled ‘just not good enough’ was almost unfathomable. That was, until the next day, when I had the opportunity to discuss my minor misfortune with other trainees, and to learn that this scenario for this module is very common. I was glad to hear the news, and again felt lucky that I am in a position where I can discuss trainee issues and receive feedback from other registrars. Who knows how long I would have felt disconcerted if I was working alone. As I said last issue, we really need to stick together and support each other through this program. It didn't take long to rework my essays, and fingers crossed this attempt is more along the lines of what the examiners are seeking. And, of course, the module is being redesigned for this year, hopefully clarifying expectations between the examiners and the examinees.

On a different note, last year I attended the NSW Lower Limb Prosthetics course. The program is well designed and problem free, having run for so many years now. It was refreshing to spend a full week away from the pressures of ward work, to concentrate on learning for learning’s sake. At the end of the week I felt like my amputee knowledge had increased a thousand-fold, and the doctors definitely outranked the physios in the final multiple choice assessment in this round of an ongoing battle.

Now it is all but a distant memory, but I know, as always, with the endless spiral of relearning and building on knowledge, that next time I visit the topic it will be much easier. As we all know it can be difficult to learn and study while working, as there are so many distractions, cancelled sessions, and fatigue at the end of the work day, and it would be great if there were more day- or week-long workshops dedicated to teaching us rehab issues.

We are still asking for submissions from all trainees to make this space completely ours, so please send in your photos, case reviews, opinion pieces, stories or anything else that may be of interest to others. You are welcome to write for clinical corner as well.

Until next time,

Jasmine Gilchrist

Trainee enquiries

For all matters and enquiries pertaining to training, please contact the Faculty Office for the current requirements.
Juggling Motherhood & Rehabilitation Training

Rehabilitation medicine is probably seen as one of the family-friendlier specialties and, as a result, there have been, and will be, many female trainees who have juggled the demands of specialty training with motherhood. This presents a number of challenges: from negotiating maternity leave, industrial issues, and training program modifications, to complying with training requirements and getting through exams. Not to mention the trials and tribulations of navigating the balancing act between work and family life.

The Faculty wishes to provide a forum where trainees can discuss issues and share information and contacts, and support other trainees in similar circumstances. We would like to hear about the experiences of current registrars who are mothers, or Fellows who have advice to offer. Please forward your submissions to the Trainee Sub-editor, jgil2726@gmp.usyd.edu.au.

To kick off the discussion I asked rehabilitation physician Dr Helen Redmond a few questions about her experiences. You will all know Dr Redmond as the Honorary Secretary of the Teaching and Learning Sub-committee, the kind doctor who approves our training program each year. Here is what she had to say about how she managed to do both jobs well.

Jasmine Gilchrist

One Rehab story

I finished my MBBS at the end of 1992 and got married about three weeks later. I was determined to start a family before I was 30, and was lucky enough to become pregnant during my third post-grad year. I had already decided to become a rehabilitation trainee and had received nothing but encouragement from my rehab mentor and folk in the Faculty about combining both motherhood and advanced training. The rehab Faculty was much more encouraging than the College of GPs which surprised me! I also had the full support of my husband.

In 1996, five months pregnant with Christopher, I began working as a rehab registrar in Balmain and RPA Hospitals. I will never forget going to my first Wednesday arvo training at Ryde where they got all the newbies to stand up and introduce themselves. There were only about three other women in the room. How things have changed!

Chris was born in May and I took the rest of that year off as maternity leave. In 1997 I went back full time and my husband took a year off as paternity leave. We had no extended family in Sydney to help with childcare and we were both uncomfortable with the idea of long day care. I wanted to prove I was serious about rehab training before I had any more children so I went back to work full time and started studying for my Part I exams (now Modules 1 and 2). Tough year but I got through.

In the following year, 1998, I found another registrar who wanted to go part time (to study for Fellowship exams) to job-share with. I worked two and a half days a week and my husband went back to work full time. We found another family with the same aged baby and shared a nanny two days a week, one day I had both boys and one day my son was with them. It was the perfect balance of family and work.

In December that year I had Isobel so I took 1999 as maternity leave. In 2000 I went back to work job sharing with another rehab registrar mum. My husband reduced his hours so there was always one of us at home with the kids. From 2001 until I completed my training at the end of 2003 I worked three days a week, mostly in the private sector.

To make things even more complicated, my marriage broke down in early 2002 (not due to the stress of the complex childcare arrangements!). This delayed my completion of training by a year. My children continued to spend 50% of their time with their Dad and the rest with me, as is still the case.

I did 12 or 14 hour shifts in emergency departments in the Illawarra fortnightly to pay my expenses, and spent most of my child free evenings studying and in study group. I could not have passed my exams without my wonderful study group – thank you, you know who you are!

I always have had the philosophy that my children were the highest priority while they were very young, and that there was no more important job than being there for them. But I also knew that they would grow, this time would pass, their needs would never be as intense again, and that it was imperative for their later development that I finish my training (if only to pay for their high school education!) So over the years my focus balanced between training and parenting felt complementary rather than in conflict ... each had its time.

I loved my work and it was a pleasure to get back to it after maternity leave. I was lucky to have a part time option close to home. I had great supervisors who also had kids of the same age, or older. I learnt on the job...
and from the job, and from my supervisors, team and patients of course. Books were secondary for quite a bit of the time but I rarely missed a Saturday morning session.

Useful things: study groups, Saturday morning sessions, learn at work from direct clinical experience, every admission is a long case, every ward round holds numerous teaching and learning opportunities, treat every patient as your teacher, ask lots of questions of your supervisor and at Ryde Wednesday sessions.

Combining parenting and training allows life to teach you alongside work. Parenting skills have a surprisingly big overlap with the rehab physician skills required to usher patients through the process of recovery:

From a rehabilitation point of view, quality of life, exercise tolerance, and physical and emotional well-being are improved post implantation. Deconditioning is common initially.

There is a paucity of published data on controlled exercise programs, although a suggested program is available in the reference provided below. In general the basic principles of exercise prescription (frequency, intensity, duration, and mode) are applicable, although there are some special considerations such as managing equipment and monitoring pump flows and blood pressure.

An ethical dilemma can arise when a patient does not make a good functional recovery. If they have high-level care needs and lack the social supports to put this in place at home, it is difficult to find somewhere for them to live. In the Sydney area at present, there are no nursing homes able to accept this device. It seems such a patient must remain in hospital for the rest of their life, or until transplant or recovery occurs (both less likely in such an impaired patient).

With thanks to Sachin Shetty.

Jasmine Gilchrist


Clinical corner

Left Ventricular Assistive Devices

Unless you have worked in specific hospitals, you may never have met a patient with an LVAD. These mechanical pumps, inserted in the abdominal cavity and connected via a port to an external computer, receive the left heart’s blood flow and are usually used as an interim measure for a person with decompensated heart failure awaiting transplant, or as a bridge to rest the heart for expected recovery.

The patient has no pulse (they sometimes find this very disturbing) and, instead of heart sounds, there is a loud and harsh continuous mechanical sound radiating through the whole chest. An LVAD has a finite lifespan, generally not more than a couple of years, and cannot be replaced.

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With thanks to Sachin Shetty.

Jasmine Gilchrist

Our CPD c. 2010

Welcome to 2010 and our CPD. It’s horrifying to think how fast the year is flying past. By the time you read this, New Year will be long past and Easter nearly upon us! Have you gone online to the AFRM webpage and started inputting your 2009 CPD points? Remember – we are not accepting paper submissions this year – it is all online. We will accept paper documentation only when you are being audited. Also, did you know that your CPD points were due to be logged by 31 January 2010 for 2009? Very few of us achieve that milestone and I certainly did not for this year!

A word of warning to old and new Fellows – we audit 10% of CPD returns every year and you have a 50% chance of being audited in a five year period. It is much easier if you keep your CPD Activities Register or a CPD diary up to date and transfer your points from there to your MyCPD register. Trying to work out in retrospect why you claimed 60 points online in a particular category when you are asked to submit your paperwork (AFRM CPD Activities register or similar, plus the evidence for your claim) is much more difficult.

New Fellows are welcomed into the Faculty in many ways. You should have received information about our Continuing Professional Development (or MyCPD) program. If not, please contact Natali Vlatko, our CPD Administrator on Natali.Vlatko@racp.edu.au or phone her on (02) 8247 6239. There are other ways of showing involvement in CPD – you do not have to use the AFRM MyCPD program but we would like you to let us know what you are doing, the system you are using, etc. Showing evidence of involvement in CPD is already compulsory in NSW & NZ, and we know it will become compulsory for medical registration nationally.

Your 2009 CPD points were due by 31 January!
Have YOU submitted your CPD points for 2009 yet?

One of the easiest ways of keeping tabs on what you have been doing is to download the current AFRM Activities Register. (The register changes slightly every year so you must use the 2009 one for last year’s claim and the 2010 for the current year etc.) However, there are other ways. For example, some Fellows use an Excel file which automatically tabulates the points for each section. Others keep details in their paper or electronic diary with a special file which includes copies of signed attendance forms, notices re Grand Rounds attended, invitations to speak at meetings or teach students, etc. We are all busy people so having a system which works for you is important. If you need some advice speak with your branch CPD rep or contact Natali.

As well, we all need to work out our individual needs for our own CPD activities – active and passive learning situations accrue points including attendance at conferences and workshops, taking part in journal clubs, self assessment programs, teaching, research, quality activities such as case note audits and mortality rounds. Do the self assessment questionnaire – this gives you points as well. You can obtain 35 points just by attending the AFRM ASM (this year combined with the WCIM in Melbourne). You can claim points for being an active member of various AFRM subcommittees as well. If you organise some CPD activities (talks, workshops, etc) for Fellows in your local geographical area, you may be able to claim points not only for attending the activity but for organising it as well.

Prior to the WCIM, I will be attending a special meeting on current issues in CPD which is being organised by the RACP and the Royal College of Physicians and Surgeons of Canada. Expect some new ideas which I hope to share with you over the next 12 months.

I am really looking forward to the meeting in Melbourne and hope to see many of you there.

Ruth Marshall
Your CPD chair
Update on Accreditation of Training Settings

The College Education Committee (CEC), the Expert Advisory Groups and the various education and training committees of the RACP, including the AFRM Education Committee (FEC) and its Sub-committees, are working towards the development of a comprehensive suite of policies and procedures to underpin the range of education programs offered by the College (Divisions, Faculties and Chapters). You can read all the recently ratified policies on the College website, Education Policy page at www.racp.edu.au/page/education-policies.

Development of the Accreditation of Training Settings Policy and the related Standards for the Accreditation of Training Settings has been completed. They were formally approved by the CEC in November last year to take effect from January 2011.

What does this mean for Rehabilitation Medicine Training Sites?

New terminology? YES

The term ‘settings’ will be used instead of facilities, hospitals or sites. Settings will refer to the full range of training environments, to sites, facilities, individual posts, networks, and consortia. A single training position may involve learning and service provision at a number of facilities. A single facility may be accredited for a number of positions, or a group of facilities may form a network or consortium to provide training to one or more trainees on rotation.

New training settings that are yet to recruit a trainee will be assessed for ‘provisional’ accreditation based on assessment which does not include trainee feedback. Once a trainee is employed, within a specified timeframe the training setting should be reassessed including trainee feedback.

Where an accreditation assessment or reassessment finds a training setting has not met the criteria, the status granted will be ‘conditional’ accreditation. A specified timeframe will be given to provide a progress report outlining steps being taken to meet the criteria, but if a report is not provided within this timeframe, or the report does not show satisfactory progress, accreditation will be withdrawn and the training setting must take steps to meet criteria before reapplying for accreditation.

New forms? YES

The Training Facility Accreditation Questionnaire (TFAQ) will be replaced by a newly designed survey form. All training settings will be initially assessed using this survey form, which addresses the accreditation criteria. All accreditation assessments must also include trainee feedback.

Will there be new procedures for accreditation of settings by AFRM? NO

The current procedures for granting accreditation and being reaccredited will hardly change:

- The Accreditation Sub-committee of the Faculty Education Committee will continue to accredit training settings that provide quality training environments with an appropriate balance between teaching and learning and service provision.
- The two-year re-accreditation cycle will continue and the six-year virtual site visit cycle will continue to be rolled out.
- Accreditation of a training setting will still need to be reassessed if the Accreditation Sub-committee learns of changes affecting the setting’s ability to meet criteria.

The newly ratified policy states that all accreditation decisions are to be based on a set of criteria that is publicly available. The RACP Standards for Accreditation of Training Settings that were ratified late last year are:

1. **Supervision**
   1.1 There is a designated supervisor for each trainee.
   1.2 Trainees have access to supervision, with regular meetings.
   1.3 Supervisors are RACP approved and meet any other specialty specific requirements regarding qualifications for supervisors.
   1.4 Supervisors are supported by the setting or network to be given the time and resources to meet RACP supervision requirements and criteria on supervision.

2. **Teaching and Learning**
   2.1 There is an established training program, or educational activities such as multidisciplinary meetings, academic meetings, rounds, journal clubs.
   2.2 There are opportunities to attend external education activities as required.
   2.3 There are facilities and equipment to support educational activities, such as study areas and tutorial rooms.
   2.4 There is access to sources of information, both physical and online, including a medical library or e-library facility appropriately equipped for physician training.
South Australia

Strategic Directions

The Statewide Rehabilitation Service Plan, 2009-2017 was launched on 15 December 2009 by Health Minister the Hon. John Hill at Hampstead Rehabilitation Centre. This comprehensive document outlines the proposed Rehabilitation System construct required for South Australia and identifies the key initiatives needed to provide more efficient and effective services. The Rehabilitation Clinical Network was set up in August 2007 to foster collaboration between clinicians, services and agencies, and to act on proposals of the Intergenerational Health Review.

Initially five clinical priority areas were identified: amputations, brain injury, older people, stroke and paediatrics. Specific recommendations in relation to older people and stroke rehabilitation have been included in the Health Service Framework for Older People 2009-2016 and the South Australian Stroke Service Plan 2009-2016 released in July 2009. Amputee and Paediatric Rehabilitation are included in the Statewide Rehabilitation Plan.

Recommendations for Brain Injury Rehabilitation are expected to be released early in 2010. Working groups are in process for spinal cord injury, orthopaedic, pulmonary and cardiac rehabilitation. A focus has been placed on the needs of Aboriginal & Torres Strait Islanders.

A specific additional area which has been recognised to need a scoping paper is Complex and Progressive Neurological Conditions and this is also underway.

Challenges

Limitation of bed capacity for the statewide neurotrauma rehabilitation services imposed through state budgetary measures has affected flow through subacute beds, highlighting the need for responsive models of care to be developed that enable practical interim solutions, pending service redesign.

A new initiative to introduce seven day a week therapy services in the Southern Region has been set up with acute rehabilitation teams at Flinders Medical Centre and Repatriation General Hospital using COAG funding.

Paediatric Rehabilitation

New ambulatory services at the Women’s and Children’s Hospital are being set up with COAG funding in 2010. Continuation of service provision by SA to Northern Territory has been secured. SA has one Fellow proceeding through the last stage of Vocational training.

Trainees

SA now has eight Vocational trainees, of whom half are preparing for the 2010 Fellowship exam.

Juniors

Congratulations to Dr Kirrily Holton (just into Vocational trainee mode) on the birth of her son Sebastian Jack in October 2009, and to Dr Maria Paul from UK, a locum consultant in the Brain Injury Rehabilitation Service (2007-08), who also has a son, Paolo Stephen, born in September 2009.

Supervisors’ Workshop

Plans are afoot to present a supervisory skills Saturday morning session on 4 September in Adelaide immediately following the ANZSCoS meeting (1–3 September 2010).

Elected SA office bearers for 2010

Chair – Dr James Rice
Hon Secretary – Dr Charitha Perera
Hon Treasurer – Dr Adrian Winsor
Branch Training Co-ordinator – Dr Lydia Huang
Branch Reports

Branch CPD Co-ordinator – Dr Nigel Quadros

AFRM nominees

Trainee representative for 2010 – to be advised
Accreditation Subcommittee – Dr Miranda Jelbart
Paediatric Rehabilitation Subcommittee – Dr Ray (Remo) Russo
Academic Rehabilitation Subcommittee – Prof Maria Crotty
AROC – Prof Maria Crotty

James Rice
Chair

New South Wales & Australian Capital Territory

The NSW Branch Annual Meeting was held on Wednesday 9 February 2010 and was well attended. A number of office bearers stood down at this meeting and the branch is very appreciative of the service they have provided, which in some cases was measured in many years. One of those stepping down was Jennifer Mann as Secretary; however Jennifer stays on the Branch Committee as the new Chair. Stuart Browne has stood down as Chair of the Education Sub-committee and Sharon Wong as Treasurer. This was also my last meeting as Branch Chair, as I have stood down from that role after two very enjoyable years. I will remain on the Committee as Immediate Past Chair. This year we also welcome Chris Katsogiannis on to what is now better termed the NSW/ACT Branch.

The composition of the new Branch Committee for 2010 is:

Jennifer Mann – Chair
Stephen Chung – Secretary
Anuka Paraparum – Treasurer
Lee Laycock – Committee Member
Chris Katsogiannis – Committee Member
( representing ACT)
Glen Sheh – Committee Member
Yvette Kosch – Committee Member
Sumitha Gounden – Trainee Representative
Chris Poulos – Immediate Past Chair

Over the past three months the branch’s main activity (outside of its core business of education) was to continue to promote the role of rehabilitation with the NSW Department of Health, and to continue to push for a fair share of Federal COAG subacute funding. At the most recent meeting held in early December 2009, Branch representatives, along with Stephen Buckley as Faculty President, met with the Deputy Director-General, Health System Quality, Performance and Innovation. The outcome of this meeting was that NSF Health has committed to resourcing a working group to look at rehabilitation redesign. We think that this is a positive outcome, although the exact details remain scant at the time of writing.

The Annual Meeting on 9 February was also combined with a CME talk delivered by yours truly. I had recently been to the USA to look at developments there in the funding of rehabilitation services, accreditation for rehabilitation facilities and programs, and new developments in outcome measures.

Just a reminder to all NSW and ACT Fellows that the CME weekend for 2010 will be in Canberra.

This will be my last report on behalf of the Branch for Rhaïa as I will be handing over this role to Jennifer Mann. For the next Rhaïa report we will also have ACT news and views.

Chris Poulos
Chair

Victoria & Tasmania

Our AGM was held on Wednesday 3 February 2010 at the Courthouse Restaurant.

The Branch Committee continues to be active trying to promote Rehabilitation Medicine, provide training for our registrars and ongoing CPD for Victorian and Tasmanian Fellows.

The highlights of 2009 were:

● The appointment of Victoria’s first Clinical Professor of Rehabilitation Medicine. Prof John Olver has forged a well earned international reputation, and is a worthy appointee in this role, which is a joint position between Epworth Health and Monash University.

● The appointment of Assoc Prof Fary Khan to the University of Melbourne. Fary is already leading multiple significant research projects in her new position.

● The successful organisation of the upcoming AFRM ASM as part of the International Congress of Internal Medicine/RACP by Dr Rob Weller and his hand-picked team of organisers.

● Introduction of the Bi-National Training Program via videoconferencing for our registrars. This has required significant adjustments to our own training program, which have been co-ordinated by Drs Genevieve Kennedy and Senen Gonzalez with assistance from Drs Sandra Farquharson, Michael Ponsford and Kirily Adam.

● An extremely successful Registrar Research Presentation evening organised by Dr Brian Anthonisz.

● Inaugural CPD weekend at Peppers Moonah Links. This was an excellent weekend organised by Dr Chris Baguley and was considered a great success by all those attending. Thanks to Dr Stephen de Graaff for

Rhaïa ● March 2010

15 ●
his interactive Supervisors’ Workshop.

- A series of CPD evenings held at the RACP headquarters in St Kilda Road, also organised by Dr Chris Baguley
- Another successful Registrar Matching Day, attended by representatives from all participating hospitals and networks. Dr Ronald Leong has run this event seamlessly for the last few years.
- Career Expo day run by Drs Nathan Johns and Pei Yu Chu, who manned the stall and fielded questions from junior doctors and potential registrars.
- Dr Kwong Teo remains tireless in his lobbying for a further Chair in Rehabilitation Medicine. Having quietly, but successfully, pushed for funding for the Universities of Melbourne and Monash posts, he is now working with Deakin University.

I want to thank the whole committee but would especially like to thank Drs Genevieve Kennedy and Michael Chou, our Honorary Secretary and Treasurer.

Genevieve has been assiduous in preparing the agendas and typing up the minutes of the Branch Committee meetings. She has provided both wisdom and perspective to many issues confronting the committee. Michael has watched carefully over our funds, and ensured absolute probity in our financial dealings. Prof. John Olver and Dr Steven De Graaff have been invaluable assets as ex-officio members.

I would like to thank the departing members of the committee, Drs Penny Smith, Genevieve Kennedy, Chris Baguley and Pei Yu Chu – I thank them all for their contribution to the Faculty. Dr Kevin Young is also retiring as the Trainee Representative and I thank him for his input also.

I would like to extend a warm welcome to the new committee members Drs Kerry O’Meara and Rachael Nunan, and to our new Trainee Representative Dr Harry Eeman.

Mary Lou Leach
Chair

Special Interest Group Reports

Special Interest Groups

In the AFRM committee structure the AFRM Special Interest Groups are sub-groups of the Faculty Education Committee. These groups are a valuable asset to the Faculty, and hence the College.

Medical specialists often develop particular interests in certain clinical areas of their specialty and this includes Rehabilitation Medicine Physicians. Such special interests often stem from a Fellow’s current medical practice and this sub-specialisation commonly leads to the acquisition of additional skills, and the knowledge of up-to-date research and developments, relevant to that aspect of the specialty.

The Faculty has now established ten Special Interest Groups (SIGs) that cover some of the clinical areas of particular interest to its Fellows. These are:

- Developmental and Intellectual Disability
- Mind
- Musculoskeletal Medicine, Pain Medicine and Occupational Rehabilitation
- Neuro Rehabilitation
- Paediatric Rehabilitation
- Prosthetics and Orthotics
- Rehabilitation and Older People
- Rural and Remote
- Spinal Cord Injury
- International Classification of Functioning, Disability and Health.

Some of the functions of the SIGs are to collect and propagate scientific knowledge, information and data specific to that interest area, and to disseminate that material amongst the members. As well as providing members access to a peer support network, the SIGs contribute to the development and staging of the Annual Scientific Meetings and they are asked to assist the Faculty Education Committee in the on-going review of the Rehabilitation Medicine training curriculum.

The SIGs are frequently asked to comment on draft policy statements and to provide advice to the Executive on specific queries relating to their areas of expertise. Many groups are working on the development of practice guidelines.

Each SIG has its own section as part of the AFRM website (http://afrm.rACP.edu.au) where some provide forums for discussing current topics and matters of mutual interest.

Review of the Special Interest Groups

At the request of the Faculty Education Committee, a re-evaluation of the SIGs and their functions was undertaken during 2008 and 2009. This review
confirmed that the SIGs are an extremely valuable part of the AFRM and that Faculty Fellows considered the number and type of SIGs to be adequate at this time.

The review resulted in some slight changes to the Terms of Reference for the SIGs, and some of the SIG administrative procedures were changed and clarified.

**SIG Membership**

One of the new requirements resulting from the review is that SIG memberships are to be renewed at least once every two years. Many Fellows have already been notified by email in recent weeks about continuing their membership and others will be contacted in the near future. If you have not been contacted and are unsure whether you are registered for a particular SIG please contact Sybil Cumming through the Faculty Office to confirm your membership status.

Similarly, if you would like to join one of the SIGs all you need to do is send an email to afrm@racp.edu.au or phone (02) 9256 5420. It costs nothing to join, you can belong to more than one and full membership is open to Fellows and Faculty trainees.

Other medical practitioners and allied health professionals who have an interest in or are actively involved in one of the areas of special interest are welcome to join the relevant SIG as invited members, who are non-voting participants in SIG activities.

_Sybil Cumming_  
Executive Officer – Education

**Developmental & Intellectual Disability (DID) SIG**

The DID SIG has been active since May 2006. To date we have focused our activities on a review of the curriculum in Developmental and Intellectual Disability and its incorporation in the AFRM Manual for Trainees. It has been officially there again for two years, and it is now clear to trainees that this is an area of Rehabilitation Medicine about which they need to know!

In preparing my recent report for the electronic newsletter for DID SIG members, I found a paper and a report that I co-authored in 1989 on _The Medical Needs of People with Developmental Disabilities: Role of Medical Specialists and Implications for Training_. The essence of the report has not changed, even if some definitions and language have gradually shifted. The focus in the report was the call for more specialists to be trained and to provide expert medical care for adult persons with developmental and intellectual disability. There was an uneasy truce then, and perhaps there still is, about the inclusion of people with cerebral palsy under that umbrella term, mainly because around 50% of children/adults with such a diagnosis do not have an associated intellectual disability. The main point however is that most people with developmental and intellectual disability as a collective, albeit heterogeneous group, still face incredible challenges to their health, function and societal involvement from childhood to adolescence to adulthood. Much important research has been done in the last 20 years to highlight specific and general aspects of health for attention, but much more needs to be done!

Many of you will recall the development of the RACP Position Statement on _Transition to Adult Services for Adolescents with Chronic Conditions_, and will recall our concern that the focus was on chronic disease and the issues for young people with disabilities were not addressed well. A working party has been formed to develop a position statement on the transition of young people with disabilities from paediatric to adult services.

A planning day was held in Brisbane on 20 August 2009 attended by representatives from paediatric and adult rehabilitation services in the areas of spinal, brain injury and developmental disability rehabilitation. We were joined by College sub-committee representatives from community paediatrics and adolescent medicine, as well as the Australian Association of Developmental Disability Medicine. We also had a parent of a man with intellectual disability in attendance.

A College Policy Officer has crafted our deliberations into a draft statement. In general the document establishes that the process of transition from paediatric services to adult services should be a formal one; that there are essential preparations which should be made during the adolescent’s time in paediatric services; and there are commitments that are necessary from the adult services. The adult services to whom the adolescents are referred may need extra training in the special procedures which may have been utilised in the child with a specific disability, and awareness raising concerning the psychosocial issues that arise in all young people as they become adults.

The Faculty expects to be sending out a discussion document for comment by early 2010.

Late last year we held the SIG Annual Meeting and re-elected our current executive for the next two years. The SIG office bearers for 2010-2011 are:

- Chair – Dr Peter Flett
- Secretary – Dr Robyn Wallace
- Executive members – Dr Geoff Abbott, A/Prof. Lynette Lee.

For 2010 we are planning to hold four teleconferences and the next annual meeting is set for November 2010.


_Peter Flett_
2010

10 – 17 April
Annual Meeting of American Academy of Neurology (AAN). Toronto, Canada. Website: http://am.aan.com

14 – 16 April
1st Baltic and North Sea Congress for P&RM. Stockholm, Sweden. Website: www.bncprm2010.org

23 – 25 April
International Congress of Neurology and Rehabilitation. Goa, India. Website: www.icnr2010.org.au

29 April – 2 May
2nd Asia-Oceanian Congress of Physical and Rehabilitation Medicine, Asia-Oceanian Society of Physical and Rehabilitation Medicine (AOSPRM) in Taipei. Website: www.aocprm2010.com Email: aocprm2010@knaintl.com.tw

5 – 7 May
Annual Scientific Meeting of Australian & New Zealand Society for Geriatric Medicine. Coolum, Qld. Website: www.anzglm.org.au

5 – 8 May
World Congress on Osteoporosis. Venice, Italy. Website: www.iofbonehealth.org

10 – 15 May
13th World Congress of the International Society for Prosthetics & Orthotics (ISPO). Leipzig, Germany. Website: www.ispo.ws

16 – 18 May

16 – 21 May
8th International Congress of Academy for Multidisciplinary Neurotraumatology. Vermont, USA. Website: www.amn2010.org

17 – 21 May

19 – 20 May

23 – 27 May
17th European Congress on Physical and Rehabilitation Medicine. Venice, Italy. Website: www.cespm2010.eu

25 – 26 May
Future Proofing the Aged and Community Care Workforce. Sydney, Australia. Website: www.changechampions.com.au

25 – 28 May
19th European Stroke Conference. Barcelona, Spain. Website: www.eurostroke.org

27 – 29 May
Biennial Scientific Meeting of the Australasian Lymphology Association. Melbourne, Australia. Website: www.lymphology.asn.au

27 – 30 May
7th World Conference, International Society for Gerontechnology. Vancouver, Canada. Website: www.sfu.ca/grc/sg2010

7 – 8 June
Canadian Stroke Congress. Quebec City, Canada. Website: www.strokecongress.ca

19 – 23 June
20th Meeting of European Neurological Society. Berlin, Germany. Website: www.congrex.ch/ens2010

30 June – 3 July
International Neuropsychological Society 2010 Mid-year Meeting. Krakow, Poland. Website: www.the-ins.org

5 – 6 July

6 – 8 July

9 – 11 July
6th International Stroke Summit. Nanjing, China. Website: www.stroke.net.cn

10 – 15 July
International Conference on Alzheimers Disease. Honolulu, Hawaii. Website: www.alz.org

26 – 27 July

5 – 6 August
Smart Strokes – 6th Australian Nursing and Allied Health Conference. Terrigal, NSW, Australia. Email: smartstrokes@conferenceaction.com.au

24 – 26 August

29 August – 3 September
13th World Congress on Pain. Montreal, Canada. Website: www.iasp-pain.org
<table>
<thead>
<tr>
<th>Date</th>
<th>Event Name</th>
<th>Details</th>
<th>Website/Email</th>
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<tbody>
<tr>
<td>1–3 September</td>
<td>Annual Scientific Meeting of the Australian and New Zealand Spinal Cord</td>
<td>Adelaide Convention Centre, Adelaide, Australia. Website: <a href="http://www.sapmea.asn.au">www.sapmea.asn.au</a></td>
<td><a href="mailto:anzscos2010@sapmea.asn.au">anzscos2010@sapmea.asn.au</a></td>
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<td></td>
<td>Society.</td>
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<td>September</td>
<td>Switzerland.</td>
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<td>28 September</td>
<td>2nd World Parkinson Congress. Glasgow, Scotland.</td>
<td>Website: <a href="http://www.worldpdcongress.org">www.worldpdcongress.org</a></td>
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<tr>
<td>29 September</td>
<td>8th Mediterranean Congress of Physical and Rehabilitation Medicine. Limassol,</td>
<td>Email: <a href="mailto:chrisfam@logosnet.cv.net">chrisfam@logosnet.cv.net</a></td>
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<td>– 2 October</td>
<td>Cyprus.</td>
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<td>1 – 4</td>
<td>6th International Symposium on Neuroprotection and Neural Repair. Rostock,</td>
<td>Website: <a href="http://www.neurorepair-2010.de">www.neurorepair-2010.de</a></td>
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<td>October</td>
<td>Germany.</td>
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<td>October</td>
<td>Melbourne, Australia.</td>
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<td>7 – 13</td>
<td>Quality Outcomes: Achieving Patient Improvement. ISQua 12th International</td>
<td>Website: <a href="http://www.isqua.org">www.isqua.org</a></td>
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<tr>
<td>October</td>
<td>Conference. Paris, France.</td>
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<td>13 – 16</td>
<td>7th World Stroke Congress. Seoul, Korea.</td>
<td>Website: <a href="http://www.kenes.com/stroke2010">www.kenes.com/stroke2010</a></td>
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<td>October</td>
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<td>29 – 31</td>
<td>49th Annual Scientific Meeting, ISCoS. Delhi, India.</td>
<td>Website: <a href="http://www.iscos.org.uk">www.iscos.org.uk</a></td>
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<td>October</td>
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<td>3 – 7</td>
<td>1st Annual Assembly, AAPM&amp;R. Seattle, Washington, USA.</td>
<td>Website: <a href="http://www.aapmr.org">www.aapmr.org</a></td>
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<td>November</td>
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<td>9 – 12</td>
<td>7th Interdisciplinary World Congress on Low Back and Pelvic Pain. Los</td>
<td>Website: <a href="http://www.worldcongresslp.com">www.worldcongresslp.com</a></td>
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<td>November</td>
<td>Angeles, USA.</td>
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<td>6 – 9</td>
<td>21st Annual National Forum on Quality Improvement in Health Care. IHI,</td>
<td>Website: <a href="http://www.ihi.org/IHI/Programs/ConferencesAndSeminars/">www.ihi.org/IHI/Programs/ConferencesAndSeminars/</a></td>
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<tr>
<td>December</td>
<td>Orlando, USA.</td>
<td>21stAnnualNationalForumonQualityImprovementinHealthCare.htm</td>
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<tr>
<td>9 – 12</td>
<td>7th International Congress on Mental Dysfunction and other Non-motor</td>
<td>Website: <a href="http://www.kenes.com/mdpd">www.kenes.com/mdpd</a></td>
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<td>November</td>
<td>Features in Parkinson’s Disease and Related Disorders. Barcelona, Spain.</td>
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### 2011

#### 23 – 26 March
  - Website: www.ecceo11-iof.org

#### 12 – 15 June
- 6th World Congress, ISPRM. San Juan, Puerto Rico.
  - Website: www.isprm.org

#### 20 – 23 June
  - Website: www.wcpt.org/congress

#### 19 – 23 September
  - Website: www.lymphology2011.com

#### 23 – 27 October
- Ageing well together: Regional perspectives. 9th Asia/Oceania Regional Congress of Geriatrics and Gerontology.
  - Website: www.ageing2011.com

#### 1 – 5 November
- 26th Annual Meeting, North American Spine Society. Chicago, USA.
  - Website: www.spine.org

#### 17 – 20 November
- 72nd Annual Assembly, AAPM&R. Orlando, Florida, USA.
  - Website: www.aapmr.org

### 2012

#### 15 – 19 May
- World Congress for NeuroRehabilitation. Melbourne, Australia.
  - TBA

#### 17 – 19 May
- 3rd Conference of Asia-Oceanian Society of Physical and Rehabilitation Medicine, AOSPRM. Bali, Indonesia.
  - Email: aosprimbali@pharma-pro.com

#### 27 May – 1 June
- Spineweek. Amsterdam, Netherlands. Website: TBA

#### 2 – 7 September
- 4th Congress of World Union of Wound Healing Societies. Yokohama, Japan. Website: http://wwwhs2012.com

#### 23 – 27 October
  - Website: www.spine.org

### 2013

#### 16 – 20 June
- 7th World Congress, ISPRM. Beijing, China.
  - Website: www.isprm.org
New PBS Listing 1st April 2009

Treatment for Upper Limb Spasticity in Adults Following Stroke

As of 1st April 2009, BOTOX® will be reimbursed for the treatment of moderate to severe spasticity of the upper limb in adults following a stroke, as second line therapy when standard management has failed or as an adjunct to physical therapy. Maximum number of treatments authorised is 4 injections per limb per lifetime.

PBS Information: Section 100 Restriction. Refer to PBS schedule for full information.

Before prescribing, please review Approved Product Information available on request from Allergan.

BOTOX® (botulinum toxin type A) purified neurotoxin complex is a prescription medicine containing 100 units (U) of botulinum toxin type A for injection. Indications: Strabismus: blepharospasm associated with dystonia, including benign blepharospasm & VIIth nerve disorders (hemifacial spasm) in patients 12 years & older; cervical dystonia (spasmodic torticollis); focal spasticity of the upper & lower limbs, including dynamic equinus foot deformity due to spasticity in juvenile cerebral palsy patients 2 years & older; severe primary hyperhidrosis of the axillae; focal spasticity in adults; spasmodic dysphonia; upper facial rhytides (glabellar lines, crow’s feet and forehead lines) in adults. Contraindications: Hypersensitivity to ingredients; myasthenia gravis or Eaton Lambert Syndrome; infection at injection site(s). Precautions: Use with aminoglycosides or drugs that interfere with neuromuscular transmission; peripheral motor neuropathic diseases or neuromuscular junctional disorders; inflammation at injection sites; excessive weakness in target muscle; pregnancy & lactation. Generalised weakness & myalgia may be related to systemic absorption. Different botulinum preparations are not therapeutically equivalent. Exercise extreme caution should substitution with another botulinum preparation be necessary. Blepharospasm: Reduced blinking following injection of the orbicularis muscle can lead to corneal pathology. Caution with patients at risk of angle closure glaucoma, including anatomically narrow angles. Strabismus: Inducing paralysis in extraocular muscles may produce spatial disorientation, double vision or past pointing. Use in chronic paralytic strabismus only in conjunction with surgical repair to reduce antagonist contracture. Spasticity: Not likely to be effective at a joint affected by a known fixed contracture. Cervical Dystonia (spasmodic torticollis): Possibility of dysphagia or dyspnœa. May be decreased by limiting dose injected into the sternocleidomastoid muscle to <100U. Primary Hyperhidrosis of the Axillae: Consider causes of secondary hyperhidrosis to avoid symptomatic treatment. Spasmodic Dysphonia: Laryngoscopy in diagnostic evaluation is mandatory. Avoid treatment in patients due to have elective surgery requiring general anaesthesia. Psychiatric Use: Safety & effectiveness below 12 years not established for blepharospasm, hemifacial spasm, cervical dystonia, hyperhidrosis, or upper facial rhytides. Safety & effectiveness below 2 years not established for focal spasticity. Caution should be exercised when treating patients with significant disability & co-morbidities. Adverse Reactions: Usually transient & occur within first week of injection. ≥1% Localised pain, tenderness, bruising, infection, local & general weakness, erythema, oedema, paresthesia, swelling, infection, tumour, contour, leg pain/cramps, fever, knee pain, ankle pain, leghargy, arm pain, hyperhidrosis, fever/flu syndrome, accidental injury, incoordination, paresthesia, asthma, headache, hyperkinesia, neck pain, dysphagia, perceived increase in non-axillary sweating, vasodilation, paralytic dysphonia (breathy dysphonia), aspiration, stridor, technical failure, blepharoptosis, face pain, ecchymosis, skin tightness, nausea, temporary lower eyelid droop, eyebrow ptosis, eyelid swelling, aching/itching sexual, feeling of tension, seizures. Dose/Administration: Use one vial for one patient. Store reconstituted BOTOX® in refrigerator; use within 24 hours of reconstitution. Blepharospasm: Initially 1.25U to 2.5U injected into upper lid medial & lateral pre-tarsal orbicularis oculi & into lower lid lateral pre-tarsal orbicularis oculi. Cumulative dose over 2 months should not exceed 200U. Strabismus: Initial doses 1.25 – 2.5U to 2.5 – 5.0U per muscle. Maximum single injection for any one muscle is 25U. VIIth Nerve Disorders (hemifacial spasm): Dosing as for unilateral blepharospasm. Inject other facial muscles as needed. Focal Spasticity in Children 2 Years & Older: 0.5-1.0U/kg body weight for upper limb & 2.0-4.0U/kg body weight for lower limb. 4U/kg or 200U (the lesser amount) for equinus foot deformity. Other muscles range 3.0-8.0U/kg body weight & do not exceed 300U divided among muscles at any treatment session. Focal Spasticity in Adults: Individualise dosing. Cervical Dystonia (spasmodic torticollis): Individualise dosing. Maximum dose 360U every 2 months. Primary Hyperhidrosis of the Axillae: 50U intradermally to each axilla in 10-15 sites 1-2 cm apart. Spasmodic Dysphonia: Bilateral injections. Individualise dosing. Glabellar Lines: 2x4U in each corrugator muscle & 4U in the procerus muscle for 20U total dose. Crow’s Feet: 2-6U/injection site, 3 sites bilaterally in lateral orbicularis oculi. Forehead Lines: 2-6U/injection site, 4 sites in frontalis muscle.

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