David Murphy recounts some of the joys & perils of working in the bush

Recently I arrived at work to find a small badge and certificate in my in-tray to recognise my twenty years of service at Bendigo Health. It led me to reflect on my time in the bush.

I came to Bendigo with my young family with a five year plan, fully expecting to return to the city at some stage. However, the five years have rolled over a number of times and I’m still here, probably to stay.

I did not attend the formal presentation for the award which was held in the rather dingy Concert Hall. This was one of the few areas of the old Benevolent Asylum which had, over the years, morphed into our current Rehabilitation and Aged Care facility.

I still have memories of having to eat dried up sandwiches when I had my interview there in 1990!

The interview was attended by a local surgeon, representing the AMA. I noticed that he was paying close attention to my CV (rather limited then!) and began to worry that he found something he didn’t like. When it was his turn to ask me a question, he simply said “Do you play cricket?” I had the feeling I was in a Monty Python sketch then realised that I had mentioned my average cricket skills in the CV. When I told him I was a handy medium pace outswing bowler he became very excited. “That’s great, the annual Doctors vs Lawyers cricket match is coming up soon and we need a bit more pace. They belted us last year.”

Needless to say I think I was recruited for my meagre sporting skills rather than those in rehab medicine. For the record, we won the match and have done so in every match since, despite the lawyers attempting to change the rules on numerous occasions. I’ve taken a few wickets, but the main reason we win now is that we can recruit a number of strapping HMOs and registrars who know how to play, including a Pakistani orthopaedic registrar who had a striking resemblance to Wasim Akram and bowled like him!

I was, in truth, recruited to develop rehabilitation programs at a well recognised geriatric centre, and set up rehabilitation at the local private hospital. In the first few years we started an amputee service, head injury and neuro rehabilitation services, and developed links with Austin Spinal team.

I can well remember Vic, the first patient to receive an energy storing prosthesis. He was in prison at the time for culpable driving and was Continued page 5 ...
This Issue

Feature story
David Murphy recounts some joys & perils of working in the bush

Editorial
President’s Report
Items of Interest
Congratulations to Tom Woolard OAM
Peter Flett remembers Dr Gabriella Malnar-Swafford

Announcements
Photo Competition
Professional Development
Trainee Matters
Editorial
Trainee Committee Report
Clinical Corner
Disparities in Spinal Rehabilitation

Training News
Faculty Education Committee Activities
College Education Committee
FIM workshops for trainees
Medical Education Officers

Branch Reports
South Australia & Northern Territory
Victoria & Tasmania
New South Wales & ACT
New Zealand

Special Interest Group Reports
Rural & Remote SIG
International Classification of Functioning, Disability and Health SIG

Calendar of Events

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Last month, I visited Africa for the first time in my life. I had been invited to do some teaching in rehabilitation and aged care at a CME meeting just outside Nairobi, for doctors and nurses working with various NGOs in Africa and the Middle East. The basic principle is that it is easier to bring a few academics to work with busy staff on location, for their CME, than to make all those workers go back to their countries of origin to attend CME courses.

Airfare pricing to get to that part of the world is a very curious business – first I discovered that it was cheaper to fly with two stops from Sydney via Bangkok and Addis Ababa to Nairobi (ET is the code for Ethiopian Airlines), than flying with just one stop in Bangkok. That fare then turned out to be cheaper than the return fare from Sydney to Bangkok alone with the anchoring Australian-based airline for the other trips. Go figure! It did mean that I could spend a weekend en route visiting with friends who have been working at the Fistula Hospital in Addis for some years now, and see what they are doing with physical and occupational rehabilitation after restorative surgery, as well as developing preventive midwifery care networks.

The surprising thing was to find interest in aged care issues as well – not a few of their patients have never been able to return home to village life and have stayed on as nursing assistants or in other work close by the hospital, some for many decades, and are now growing old with a disability. Many of their non-disabled peers have not survived to the same age, for lack of local medical care and the rigors of rural life, not to mention the effects of HIV/AIDS upon the population of sub-Saharan Africa.

The other surprise was to find out just how many companies from India and China are setting up in business in that part of the world. In Ethiopia’s collectivist past, rural life, not to mention the effects of HIV/AIDS upon the population of sub-Saharan Africa, has many non-disabled peers have not survived to the same age, for lack of local medical care and the rigors of rural life, not to mention the effects of HIV/AIDS upon the population of sub-Saharan Africa. In Ethiopia’s collectivist past, rural life, not to mention the effects of HIV/AIDS upon the population of sub-Saharan Africa.

The abiding impression is of vast numbers of young adults moving about in the early mornings, presumably heading off to work, and on the move again in the evenings. Despite everything else, there is still a huge population boom in process, but the whole setting felt quite different to me than crowded places in India and China, for example, with the same sorts of population pressures.

In talking about this with colleagues working locally, they spoke about the tribal and linguistic fragmentation of many African nation-states (whose boundaries are often a legacy of 19th and 20th century colonial adventures), and how national policy and goals were thus sometimes quite difficult to achieve with consistent progress. Of course, it is far more complex than this, but it did leave me thinking that the big-state heritage of many Asian countries, with greater commonality of language, education and social organisation, provides a more fertile ground for the development of specialty care like our own, than in Africa.

South of the Sahara, I note that only South Africa has an office of Rehabilitation Practitioners clearly visible. Is anyone interested?

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accompanied to his first fitting by two burly guards. They seemed very concerned and came over to speak to me. “Hey Doc, we are a bit worried about this leg Vic’s getting. Is he going to be able to jump over the jail wall with it?” Of course he didn’t, last time I saw him at the clinic he was out of jail and doing well. He proudly told me he was building his own house, out of old tyres! You meet some interesting types in the country!

My practice has changed quite a lot since the early days, which reflects the changing demographics of the region. I’m doing a lot more geriatric rehabilitation now, as we have a very high proportion of people over 75. I think this would be the same in many rural areas and I would suggest that any rehabilitation physician planning to work in the country has some exposure to aged care in their training. An issue for us is that our geriatrician workforce is dwindling.

When I came to Bendigo there was a Physician Geriatrician and no less than seven staff geriatricians who had a Diploma in Geriatric Medicine. We now have four geriatricians, three of whom are close to retirement. There are five rehabilitation physicians in town, two of whom, I can proudly say, did much of their training in Bendigo.

I have taken on a key role in the Memory Clinic. I thought I wouldn’t enjoy working in the field of dementia, but have found it to be fascinating and fulfilling, although it would be good if there were drugs that really worked!

Once a month I travel to Mildura, 400 kms north by small plane, to attend a satellite clinic. I’ve had some interesting trips, through summer thunderstorms and winter fog. The most bizarre was when Mildura was engulfed by a locust plague, so severe that the jets were banned from operating. Our little prop plane got up in the air OK, although the passengers relaxed and read or went to sleep, until half way through the flight. The lady behind me tapped me on the shoulder and asked me if I could smell something burning, which I could. Thoughts of whether my life insurance was up to date flashed through my mind before I got the pilot’s attention and informed him of the rather acrid smell. He sniffed the air and looked around in a quizzical manner for a while, then calmly stated, “its ok, I’ve just turned the heaters on”, toasting a few dozen locusts in the process!

The Mildura trips are popular with my Registrars and HMOs; their treat for enduring a bumpy plane ride is lunch at one of Stefano de Pierr’s cafes. The Registrars often comment on how many of the patients and relatives I know, I have treated three generations of quite a few families. One does have to become accustomed to meeting patients anywhere you go in town. If I want to find a patient I just have to walk down the Mall! I bumped into Jeff, one of my first ABI patients outside Bunnings last week. He was manning a BBQ for a fund raiser. I asked him if he remembered me, after prompting he said “you’re that bastard!”

He did have some frontal lobe issues. He wasn’t able to return to his work at the Defence Factory where he was a fitter making components for the Collins class submarines (or maybe he did go back to work and that’s why they are no good!). He now has a mobile BBQ business and does some mowing and gardening and so I’ve got him coming around to tidy up at home.

By this time the plane had turned from white to a dirty grey brown colour. All went well and the passengers relaxed and read or went to sleep, until half way through the flight. The lady behind me tapped me on the shoulder and asked me if I could smell something burning, which I could. Thoughts of whether my life insurance was up to date flashed through my mind before I got the pilot’s attention and informed him of the rather acrid smell. He sniffed the air and looked around in a quizzical manner for a while, then calmly stated, “its ok, I’ve just turned the heaters on”, toasting a few dozen locusts in the process!

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Such are the perils and joys of working as a rural rehabilitation physician. Would I have changed my plans 20 years ago if I knew what I was getting into?

No way.

(Above) The amputee team from Bendigo takes to the air.

**Items of Interest**

**Congratulations to Tom Woolard OAM!**

Dr Tom Woolard was recently presented with the Medal of the Order of Australia by the NSW Governor, Her Excellency Professor Marie Bashir, for service to rehabilitation medicine in the Hunter area as a practitioner and administrator.

**Thomas John Woolard**

Tom Woolard, recipient of the RACP John Sand Medal in 2010, received the Order of Australia Medal in 2011. Tom has been described by his colleagues as a quiet, committed, considered, broadly consultative, inclusive, transparent and measured person.

In 1966 Tom joined the Executive staff at the Royal Newcastle Hospital (RNH) as Director of Medical Services (DMS) from where his contact with skilled, innovative physicians (like Dr. Richard (Dick) Gibson) and together a passion for a fairer community, led him towards an initial interest in Rehabilitation Services.

This move to Newcastle was the beginning of a long association with the region which was to have a substantial impact on the development of rehabilitation medicine in the Hunter and indeed across the State.

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Dr Tom Woolard was recently presented with the Medal of the Order of Australia by the NSW Governor, Her Excellency Professor Marie Bashir, for service to rehabilitation medicine in the Hunter area as a practitioner and administrator.
In 1971 Tom became a Foundation Fellow of the Royal Australasian College of Medical Administrators and designed and implemented an ongoing course in Management for Heads of Departments at the RNH. In the early 1970’s, Tom was a member of the group of Newcastle doctors and other interested persons who made the (successful) presentation to the Karmel Committee for the establishment of a Medical School at the University of Newcastle. With the establishment of the Medical School Tom became the Clinical Lecturer attached to the Population Medicine Department which gave him the opportunity to introduce the concepts of Rehabilitation Medicine to the Newcastle medical students.

In 1976, seeing his clinical future in what was then the embryonic beginnings of Rehabilitation Medicine, he courageously resigned from his full-time staff post at the RNH to set up the first Rehabilitation Medicine and Occupational Medicine practice in the Hunter region which attracted the notice of the RNH and Tom was appointed Director of Rehabilitation (RNH) and subsequently Regional Director of Rehabilitation.

Tom was invited to become a Foundation Fellow of the Australian College of Rehabilitation Medicine in 1980 and was subsequently admitted as a Fellow. In 1983 he was also admitted as a Fellow of the Australasian College of Occupational Medicine and in 1993, Tom became a Fellow of the newly formed Australasian Faculty of Rehabilitation Medicine (RACP).

Tom’s compassionate nature was evident in his recognition of the need to educate migrant workers regarding upper-limb and low back pain and he was instrumental in developing and running a Pain-Management program in several languages for these marginalised people. As a result of a Grant from the World Bank Health Services Division, Tom was involved in advisory work to the Chinese Government in 1992 which focussed on the basic infrastructure required to develop Rehabilitation Services in China.

Tom retired from the position of Regional Director, Rehabilitation Services in 1994 and subsequently continued work as the Medical Director of Hunter Rehabilitation Service until his retirement from clinical work in 2005, continuing on as Emeritus Consultant.

Tom’s book, published in 1992, titled “A History of The Hunter Rehabilitation Service” is a fascinating record of events leading up to and the operation of this service.

Congratulations Tom!

Peter Flett remembers Dr Gabriella Molnar-Swafford

The December edition of Rhaïa included an article on the death of Dr Gabriella Molnar-Swafford. Clinical A/Prof Peter Flett has fond personal memories of Dr Molnar (as she was known to Peter) and attributes her with changing his career.

In Peter’s words:

“Dr Gabriella Molnar, as she was in 1981/1982, came out to Australia for the inaugural lectures of the Australian College of Rehabilitation Medicine. She was the sole international invited speaker in paediatric rehabilitation medicine. She spoke for an hour, received a standing ovation and changed my career. I subsequently visited, studied and stayed with her first husband in CA, USA and enjoyed the experience immensely.

No-one else has affected my passion for children with disability quite the same ever since. (The College I recall was inaugurated by Sir Zelman Cowan, Governor General, who died this weekend).”
Items of Interest

**Professional Development**

**Adrian Paul Memorial Prize 2012**

The Adrian Paul Memorial Prize has been increased to $1,000!

*Criteria for the 2012 award are as follows:*

1. A paper or poster presented at the AFRM Annual Scientific Meeting / WCNR 2012

   or

   A scientific paper accepted for publication in a refereed medical journal during 2012.

2. A registered trainee of the Faculty or a Fellow during the first year after qualification.

*To apply for the award for 2012, copies of the paper, poster (or abstract) must be forwarded for consideration by the Faculty Education Committee by email to: afrm@racp.edu.au no later than 1 November 2012.*

**AFRM Awards Recipients**

**Congratulations!**

**AFRM Bruce Ford Travelling Scholarship ($10,000)**

Dr Julia McLeod will investigate improving system performance, patient satisfaction and education; using pre-processing and standardisation of resident training to improve performance of an academic ambulatory pain clinic at John Hopkins University School of Medicine, USA.

**AFRM Ipsen Open Research Fellowship ($15,000)**

Dr Marina Dementrios will investigate the effectiveness of outpatient rehabilitation following botulinum toxin type A (BoNT A) treatment for upper and lower limb spasticity in persons with stroke at Melbourne Health, VIC.

**AFRM Ipsen Trainee Research Fellowship ($6,000)**

Dr Alexis Berry will investigate the effect of botulinum toxin type A on seating outcomes and personal hygiene in treatment of spasticity of the lower limbs in adults with moderate to severe cerebral palsy (GMFCS 3, 4, 5) at Concord Hospital, NSW.

**CPD points – It’s that time of the year again**

If you are reading this article and it is before 1st April 2012 and you have not yet submitted your CPD points on-line, stop reading the article and go on-line right now and submit your points. At least 60 and preferably 80 or even 100. Do not pass go, do not collect $200, do it right now!

(If you are unsure what you need to do, please speak to your local CPD rep or call the Faculty CPD officer at the RACP or email facultycpd@racp.edu.au.)

Now that you have submitted your CPD points, you need to see whether you will be amongst the 5% of Fellows who will have their CPD returns audited. If you are not being audited, you will be issued with a certificate by email within a month or so, however, if you are to be audited, you will receive a letter explaining this and requesting that you submit all your paper verification.

*What verification will be required?*

- If you are claiming attendance at a conference, a copy of the certificate of attendance is the best option plus, if possible, information regarding the conference program, such as the conference timetable (photocopied or scanned) but not the entire abstract book.
- If you gave a presentation at the conference, a copy of the abstract would be useful and a mark on the timetable where you gave the paper.
- If you published a paper during the year, the front page of the paper is sufficient.
- If you gave a new presentation, the first slide is sufficient plus a copy of the invitation or a thank you or a diary note should be sufficient.
- If you attended monthly morbidity and mortality meetings and you claim these points, then a copy of your diary note should be sufficient.
- If you attended grand rounds, then a copy of the signed attendance roll or information regarding the speaker and topic and your diary note will be sufficient.
- If you attended journal clubs, then the title of the paper being discussed and the presenter and the date, for example, would be sufficient.

• If you were involved in a unit audit, then a title of the audit, the dates, the presenter or the leader and your role in the audit, will be sufficient.

These are just examples and your CPD rep should be able to help you get your paperwork together if you need some help. Ideally, if you could then scan your information and email it, then that will reduce the paper load at the other end as your CPD colleagues on your CPD Committee will be reviewing your submission electronically whenever possible.

We hope that the audit process will be completed by 30th June.

So, if we are going to finish the audit process by 30th June, then what else is your CPD committee doing for you in 2012?

Your CPD committee is continuing to work on our review of the on-line CPD process, the points attribution, etc., so that we can move to the RACP MyCPD process once that process has been fully reviewed and updated. Currently, your CPD Chair (the writer of this article) is on the RACP working group reviewing the RACP MyCPD program so that when your CPD committee agrees on your behalf that our Faculty CPD should mirror the RACP MyCPD program (with appropriate changes to meet the AFRM Fellowship’s requirements) we will all know that we have moved across to an even better system than the one we have at present.

In the meantime, please do not hesitate to talk with your CPD colleague on your CPD Committee for help. Your CPD Chair (the writer of this article) is also a part of the AFRM Faculty CPD sub-committee working group reviewing the RACP MyCPD process (with appropriate changes to meet the AFRM Fellowship’s requirements) and we will all know that we have moved across to an even better system than the one we have at present.

The Adrian Paul Memorial Prize has been increased to $1,000!

With best wishes for the rest of 2012

RUTH MARSHALL
Your CPD Chair
This is a retrospective study which reviewed seventy-five patients who had SPC (Suprapubic catheter) inserted for neurogenic bladder secondary to spinal cord injury. Charts, investigation and scan results reviewed and questionnaire sent to patients to document complication and patient’s satisfaction with SPC. In summary:

- Of the seventy-five patients, one had died, three deferred participation and nine were not able to be contacted.
- Of the sixty-two patients, forty-two had SPC as a primary method, sixteen as a secondary method and four as temporary bladder management.
- In our series of forty patients who had SPC as the primary method of managing their bladder, there was no upper tract dilatation or cortical thinning on imaging of their renal tract.


REFERENCE:


Welcome to the new trainees, and congratulations to those who have moved on to become Fellows. My own plans to finish up training after this year (exams pending of course) have been happily delayed by the arrival of a baby girl (2 weeks early, after I had been on maternity leave long enough to set up the nursery, wash the little clothes, pack my hospital bag and begin to think about putting my feet up…). Even though I come into regular contact with many trainees and consultants here in NSW, and am on good terms with several different JMO units, there was plenty of mystery and misinformation when I was planning my maternity leave. I thought I’d share some of my experience, as it turned out quite a lot better than I was led to believe it would be. My two biggest concerns were:

- The dilemma between securing the maternity leave I was ‘entitled to’ and applying for a job I knew I would not end up working in, and
- Loss of long service leave and sick leave after a break in my contract with NSW Health.

My current contract, expiring mid-January, would only cover a few weeks of my maternity leave (bub also due mid Jan), and I thought that my options would be to apply for a new position and then announce my intention to take the term off, or ‘forfeit’ the 14 weeks paid leave in the interests of being fair to a potential employer/ rehabilitation unit (as we know leave isn’t usually covered and said ward would likely be without a registrar). After speaking with a number of consultants and registrars I chose the latter and resigned myself to some frugal times but my current employer paid out the entire 14 weeks in a lump sum, as apparently anyone who has been employed by NSW Health for 12 months (it doesn’t matter which hospital) is entitled to. So there is worry one out of the way, and don’t forget the $570 a week for 18 weeks paid parental leave that we are also all eligible for. Bring on the champers instead of the sparkling wine (consumed immediately after a feed of course, so as not to intoxicate the little one).
Trainee Committee Report

Welcome to another year! I hope everyone is settling into their new terms and progressing through their learning objectives. There have been a few changes to the membership of the Trainee Committee for 2012. We warmly welcome David Skalicky as the NSW/ACT Trainee Representative and Lucy Ramon as the Policy and Advocacy Committee Representative, Benoosh Talboie as the College Trainee Committee Representative, and thank Kiriell Holton for taking on the Trainee Teaching and Learning Sub-Committee position in addition to being the state representative.

This year the Trainee Committee hopes to continue to represent the views of the trainees and to meet your needs. We continue to meet regularly via teleconference, and are more than happy to discuss any concerns that you may have. Whilst some matters, such as the increase in training fees, may be beyond our influence there are many other matters for which we can have direct input. Feel free to contact your state representative or myself, either directly or through our wonderful Faculty support staff.

This year, depending on numbers, we hope to have the first national training day and would welcome any suggestions of topics that you would like to see included. There are many other training opportunities being arranged and this year we hope to have a national calendar of training events available for the first time. If you are aware of anything that you think should be included then please let us know.

I wish everyone a successful and enjoyable term and for those of you studying for Fellowship exams this year – good luck!

Sincerely
Alexis Berry

Clinical Corner

Author Rabin Bhandari

Rehabilitation medicine and the division of labour; Adam Smith gives a famous example of the benefits of division of labour producing qualitative and quantitative improvements in manufacturing; the process of pin-making. He cites that one man, making the entire pin himself, “could scarce, perhaps, with his utmost industry, make one pin in a day, and certainly could not make twenty.” But, by dividing the process into “peculiar trades” (with one man drawing out the wire, one cutting the wire, and another grinding it to place the head, etc.), those ten or so men, “could make among them upwards of forty-eight thousand pins in a day.”

Now by Smith’s own admission, pin-making is only a “trifling manufacture”. How then would the principles of the division of labour apply to something as complex as human disability? It seems patently obvious that there are numerous clinicians involved in the care of the more challenging rehab patients: from the various shift-working nurses performing, assisting, and educating about the self-care duties; to the physiotherapists assessing, manipulating and exercising the bodies; to the rehab physician, constantly re-evaluating and medically aiding the progress and prognosis. But how can we continue to improve our efficiency and productivity? Smith’s thesis infers that we should invariably divide the minutiae of disability care even further, to Henry Ford’s practical conclusion of a production line: with each team member responsible for a duty as small and specialised as the standing-up of patients (but not the sitting-back-down), again and again, all shift, every shift, forty hours per week.

We are all aware that the patient-centred-approach to rehabilitation medicine is doggedly individualised and not as suited to the production-line mindset of Ford. It is evident that there needs to be flexibility in the approach to each patient; the clinicians need the propensity to learn and adapt for new situations. Nevertheless, a defeatist approach to improvement in rehab will probably engender a Panglossian paradigm: no matter what new we do, not much will be better because we have reached the zenith of care. Already, there is a division of labour in care: we do not expect that a speech pathologist will also perform neurogenic bladder guidelines and techniques for spinal care. For reasons of convenience and cost, the expectation for most rehab clinicians here in Australia now is that although there may be a few specialised clinics (e.g. amputees, motor neurone disease, spina bifida), most of the caseload is general in nature. The general physiotherapist is usually expected to be quite expert in amputees, neurological gait retraining, spasticity, orthopaedics, cardio-vascular re-conditioning; the general speech pathologist is expected to be quite expert in the treatment of dysphagia, dysphonia, dysarthria, and dysphasia due to a hodgepodge of conditions; the rehabilitation physician is expected to be quite expert in the management of a multitude of conditions and diseases. Are these expectations justifiable? Do we not owe it to the patients to research the implementation of more specialised care?

Disparities in spinal rehabilitation

Dr Ajay Bharatula, Rehabilitation Registrar, Victorian Trainee Representative

In a meagery such as Kolkata, it is exciting to see the maze of bypass roads, flyovers, monorails and metropolitan train lines being built. Around it however, remains the vestiges of broken, poorly constructed and neglected infrastructure. After a while, one can appreciate a sense of organisation and unwritten code within this chaos. The opulence of a Hyatt hotel, which hosts a visit from the King of Bhutan, is a stone’s throw away from one of Kolkata’s several thousand slums. The vision of well designed cities is certainly there, but it amplifies the disparities between those that have benefited from progress and those left behind. The result is a land of dramatic contrast.

This was the setting for ISSICON the International Spine and Spinal Cord Injury Conference, held in Kolkata, India. The contrasts within the current state of the speciality in India evoked mixed emotions; the progress made was laudable while the relics of the past were frustrating. Although designed as a scientific meeting, it was inevitable that it would spark discussion around the broader context within which rehabilitation exists. For some delegates and presenters, this created an opportunity to articulate the deficiencies within their healthcare system. Rather than a criticism of the country, this approach broadened appreciation of the challenges for locals and reminded me of the positive aspects of spine care in Australia.

The meeting gathered international experts from neurosurgery, orthopaedics and neuro-urology such as Professor Manfred Stohrer, Mr Patrick Kluger, Mr Ziad Al Zoubi and Mr Hans Joseph Erl. They spoke on topics as diverse as stem cell technology, neurogenic bladder guidelines and techniques for spinal surgeries. Chief guests included Professor Douglas Brown, from the Victorian Spinal Cord Service and President Elect of International Spinal Cord Society, and Dr AK Mukherjee, Director General of the Spinal Cord Society (India chapter).

A small contingent of healthcare professionals representing various local contexts was present. To put things into context, roughly 50 recently graduated rehabilitation Fellows cater for 1 billion Indians compared to roughly 8 new rehabilitation Fellows for 5 million Victorians. A large number in the field in India have other training backgrounds. It is not unusual for rehabilitation practitioners to have post-graduate training in surgical fields. As a consequence, they add to their service by doing tendon transfers, fascio-cutaneous skin grafts and cystotomies.

While wearing many hats at once can be rewarding, burn out and accountability are also important considerations. It appears the demographic of spine injury mechanism is changing from a predominance of falls to a higher proportion of road traumas. Commonly, poor individuals from labouring backgrounds who suffer a spinal injury also suffer a loss of livelihood which sends their families back into poverty.

Some form of health protection is provided by the Government, but only a minority have health insurance. The costs of rehabilitation care, aids and equipment are largely self-funded. Prevention was a smaller feature of the conference, with references to the benefits of harnesses when climbing scaffolding and helmets for bike riding. The roads are littered with potholes, broken tarmac and thick traffic making pre-hospital acute spinal immobilisation a real problem. Moreover, in a state of over 80 million people, there is no dedicated spinal injuries centre in West Bengal.

Speakers highlighted the importance of recognising the rights of the person with disability as per the United Nations declaration. However, the frustration of providers and recipients in achieving this was at times palpable. The paradigm of ample knowledge, but having simultaneous skill and resource deficits was evident in the ways that local practitioners negotiated best practice. A number of spinal cord injury services have been developed within the country, but with significant variability in the technical expertise available such as peer counsellors and
neuropsychologists. Some delegates commented on the problem of delay or absence of referrals to rehabilitation and loss to follow-up post-discharge. One presentation looked at delayed referral to rehabilitation and associated higher rates of complications including pressure sores and contractures. Another delegate highlighted how poverty inhibited self-funding of pressure cushions and the lack of preventative, cost-effective seating and posture measures. Alongside expensive pressure sore dressings was advocacy for inexpensive topical EU Sol and phenyltoin liquid. There was support for the use of expensive, but controversial, recombinant human platelet-derived growth factor for wound healing. This was balanced by the timeless advice, “put anything on the wound but the patient”. A simple barometer device to estimate intravesicular-detrusor pressures was suggested as a substitute for scarcely available video urodynamics. Another paper commented on the diverse, inaccessible and challenging home and public space environments in India. The consequence of this for differently able persons was isolation within homes, reduced participation in recreational activities such as attending a park and difficulty using public transport. Another delegate was disappointed by the accessibility of the conference. Contrasts are useful to highlight differences but only a limited perspective can be garnered from a single delegate.

Promising institutions include the Margaret and Paul Brand Spinal Injuries Centre, Vellore and the Indian Spinal Injuries Centre, New Delhi. The development of the latter was driven by a former Indian army general who had scaled the heights of Mt Everest before suffering a spinal cord injury as a result of gunshot trauma in battle. In their own marketing material, the facility boasts of “first world care, third world cost”, “no waiting periods, even for major surgeries” and “five star luxury rooms” to prospective tourists. At the same time they have reserved 30 beds within a 150 bed hospital for the poorest citizens. A valuable contribution of the forum was recognition of the need for a disease registry of spinal cord injuries to distribute resources equitably, target intervention and preventative measures. The role of government was also evident, with the promise of a spinal injuries centre for the city of Kolkata being announced by a Cabinet Minister. The key changes are summarized on the Austroads website and detailed in a comprehensive report also available on the site.

The National Transport Commission and Austroads are pleased to announce the release of Assessing Fitness to Drive 2012. As many patients hold a driver licence, health professionals have an important role in supporting road safety through their management of fitness to drive. The National Transport Commission and Austroads are pleased to announce the release of Assessing Fitness to Drive, the 2012 revised national medical standards for driver licensing. Assessing Fitness to Drive has been extensively revised, drawing on recent research and expert opinion on the impact of various chronic medical conditions on driving.

New features

The new edition features a simplified structure with ten chapters (reduced from the original 23) which focus on the health conditions likely to affect driving. Fellows and trainees should expect to receive a copy in the post shortly. Information about the impact of medications is also included in Part A of the publication. The key changes are summarised on the Austroads website www.austrroads.com.au and detailed in a comprehensive report also available on the site.

Announcing “Assessing Fitness to Drive 2012”

As many patients hold a driver licence, health professionals have an important role in supporting road safety through their management of fitness to drive.

The Faculty Education Committee (FEC) last met in December last year and again on 5 March 2012. The two-year term of office for most of the members expired on 31 December 2011 and expressions of interest for these positions were called for through the E-Bulletin in October last year. I am pleased to announce that the following members have been appointed or reappointed for another term:

- Dr Geoff Abbott - Lead Fellow in Accreditation
- Prof Ian Cameron - Lead Fellow in Academic Rehabilitation
- Dr Jennifer Chapman – Lead Fellow in Annual Scientific Meetings
- A/Prof Andrew Cole - Lead Fellow in Physician Educators and Incoming Chair of the FEC
- Dr Toni Hogg - Lead Fellow in Overseas Trained Physicians & Honorary Secretary of the FEC
- Dr Ruth Marshall - Lead Fellow in Continuing Professional Development
- Dr Barbara Hannon – newly appointed Lead Fellow in SIGs
- Dr Ray Russo is the newly appointed Lead in Paediatric Rehabilitation Medicine and Chair of the Paediatric Rehabilitation Advanced Training Committee. It is very disappointing that no expressions of interest were received for two positions:
  - Lead Fellow in Assessments
  - Lead Fellow in Teaching and Learning

These positions are now casual vacancies that the FEC will be endeavouring to fill the positions as soon as possible. If you are even slightly interested please contact me or the Faculty Office for more information.

In December the FEC selected Dr Michael Tan as the winner of the 2011 Adrian Paul Prize for his publication, Survival after rehabilitation for spinal cord injury due to tumour: a 12 year retrospective study. Dr Sureshbabu Subramanian is the 2011 IPSEN Award winner for the Best Trainee Presentation on Neurological Rehabilitation at the Annual Scientific Meeting in Brisbane for the poster entitled, Consequences of Supratubular Catheter in Spinal Cord impairment.

Our Scientific Program Subcommittee will soon be making plans for the AFRM’s 21st Birthday! The Faculty’s 21st Annual Scientific Meeting will be in 2013 as part of the College Future Directions in Health Congress to be held in May. This coincides with the College’s 75th anniversary celebrations.

College Education Committee

Two more education policies were ratified by the College Education Committee (CEC) in November 2011. These policies apply to all of the College’s training programs. All ratified policies are available on the Education Policy page on the College website, found at: www.racp.edu.au/page/education-policies. Some of these policies will result in changes to the AFRM’s requirements for training such as the Flexible Training Policy, which comes into effect from 1 July 2012. From that date trainees will be able to take 8 weeks leave in 12 months, not including parental leave, without losing training time, part-time training of a minimum of 0.4 FTE will be approved and the time limit for trainees to complete all training and assessment requirements will be extended to 10 years (4-yr program) or 8 years (3-yr program).
The Progression through Training Policy that is effective from 1 January 2013 will mean that any Faculty trainees who have been discontinued because of failure to progress will not be eligible to re-enrol in College training programs. This policy also states that training periods of less than one continuous month will not be approved and that the term accreditation of training will be renamed certification of training. However, there will be no changes to Faculty’s current 3-year rules to pass the Modules 1 and 2 and the AFIRM’s Fellowship Examinations.

The CEC also resolved that trainees enrolled in the PREP Advanced Training Programs across the Divisions, Faculties and Chapters will be required to complete all 2011 PREP training requirements. This means that if any of the Faculty’s PREP trainees has 2011 training requirements (Trainee Term Evaluations Form for Term 2, 2011 or Term 1 and Term 2 Supervisors’ Reports including In-training Long Case Assessment results) that have not been completed and submitted before 30 June 2012, that training period will no longer be eligible for certification.

To support supervisors the College has also prioritised the development of a supervisor professional development program and curriculum and a review of the supervision model. A/Prof Andrew Cole, the Faculty’s lead Fellow in Physician Educators will be telling you more about these initiatives in the coming months.

**FIM workshops for trainees**

I hope you all noted the recent item in the weekly E Bulletin about the Open FIM workshops that AROC has scheduled for this year. Faculty trainees who are yet to complete their FIM training requirement should try to attend one of these sessions.

At present few registrations have been received and these workshops require a minimum number to proceed otherwise they will be cancelled. The NSW workshop was on 6 February 2012. Other proposed dates are:

- 5 March 2012 in Queensland
- 12 March 2012 in Victoria
- 23 March 2012 in New Zealand

For further information please contact Julie de Clouet, the FIM Co-ordinator at the Australian Health Services Research Institute (AHSRI) on phone +61 2 4221 5282 or email juliede@uow.edu.au

**Medical Education Officers**

**What is a Medical Education Officer (MEO)?**

The Royal Australasian College of Physicians first appointed Medical Education Officers (MEOs) in 2009 to provide information about the PREP (Physician Readiness for Expert Practice) programs and to run workshops/sessions and one-on-one consultations for trainees and supervisors in each state. There is at least one Medical Education Officer (MEO) in each state across Australia and one in New Zealand.

The MEO’s primary role is to facilitate implementation of all the RACP education programs, with particular focus on the PREP Basic, Advanced, Chapter and Faculty Training programs. MEOs provide onsite training for supervisors and trainees at metropolitan and regional hospital locations and at their place of work, within each state. They are usually based in the College’s state offices and work closely with state committees and the Supervisor Learning Support Unit (previously Physician Educator Unit).

**What can an MEO offer?**

To support the implementation of the RACP PREP education programs including those of the AFIRM, MEOs are available to arrange and facilitate locally-based sessions regarding the enhancements supporting the education programs, in various formats. MEOs, in Australia, are also available to hold sessions on Continuing Professional Development of Fellows. Within New Zealand the sessions are conducted by the Communications and Member Services Officer.

Usually, these sessions are 1-2 hours in duration and either held onsite at a hospital or at one of the College’s state offices. The sessions can be generic for PREP Advanced Training or specialty specific, depending on the need identified locally. These sessions can be aimed at trainees, supervisors or a mixed audience.

**How to contact an MEO if you would like to arrange a session?**

The Faculty Office staff can contact the relevant MEO with your requests or you can contact them directly. The MEOs can be contacted by phone or email as follows:

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<th><strong>Carmen Axisa</strong></th>
<th>New South Wales and ACT</th>
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<td><strong>Email</strong></td>
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<td><strong>Phone</strong></td>
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<td><strong>Phone</strong></td>
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**Training enquiries**

For all matters and enquiries pertaining to training, please contact the Faculty Office for the current requirements.
South Australia & Northern Territory

The SA Branch has had another busy end to the year. The Annual Scientific meeting was held on 18 – 19 November 2011 at Mt Lofty House. Guest speakers were:

- Mr Alex Ward, an Adelaide lawyer with significant experience in the medicolegal field
- Dr Mary Sipsky, Rehabilitation Physician recently appointed to Hampstead Rehabilitation Centre spoke on Rehabilitation Medicine practice in the USA
- Dr Andrew Zaczer, Neurosurgeon at the Royal Adelaide Hospital enlightened the audience with a talk on Deep Brain Stimulation for movement disorders – practical aspects for care in rehabilitation
- Professor Lorimer Moseley, Professor of Clinical Neurosciences and Chair in Physiotherapy, UniSA spoke on Body in mind: making sense of brain changes in chronic pain & their implications for rehabilitation.

These excellent talks were well received by the audience. Each of the twelve local trainees in Rehabilitation Medicine gave a brief presentation either on their research project or an interesting clinical case. The prize of $200 for the best presentation was awarded to Dr Nalinda Perera for a presentation on the relationship between pain and its cognitive interpretation.

The Rehabilitation Medicine department at the Queen Elizabeth Hospital (QEH) recently held a one day workshop titled, Upskilling in Spasticity Management and Casting. Dr Melissa Nott, an Occupational therapist at Westmead Hospital, was the convener. The program was attended by all rehabilitation specialists and trainee registrars from the QEH as well as allied health staff from Spinal Cord Rehabilitation and Brain Injury Rehabilitation ambulatory programs.

The following nominations have been received for SA office bearers for 2012-13:

- Chair: Charitha Perera
- Honorary Secretary: Nigel Quadros
- CPD Co-ordinator: Anupam Datta Gupta
- Branch Training Co-ordinator: Andrew Wilkinson

James Rice
Outgoing Chair

Victoria & Tasmania

Our ABMM was held at St Katherine's Restaurant on Friday 10 February 2012.

The branch continues to strive to provide quality training in Rehabilitation Medicine, provide ongoing CPD opportunities for our Fellows, and to promote Rehabilitation Medicine as a medical career.

The highlights for 2011 have been:

- Negotiations to meet on a regular basis with the Victorian Department of Health and representatives of the ANZSGM and the ANZSPM to discuss issues of relevance to Sub-Acute Services.
- A commitment of seed funding from the Victorian Department of Health to improve Rehabilitation Training in Victoria. An Extraordinary Meeting of Rehabilitation Clinical Directors was held on 3 February to discuss strategic planning for the use of this funding opportunity. EOI from interested ‘lead hospitals’ has been requested.
- Dr Genevieve Kennedy has, again, worked tirelessly to co-ordinate the Teaching and Learning Sub-committee, and to organise the Registrar Wednesday afternoon program.
- Dr Kerry O'Meara has successfully organised a program of CPD evening educational sessions, which now can be video-conferenced on request to rural or Tasmanian sites. She and Dr Grantly Pearce have put in a great deal of work to organise an educational workshop for Fellows and Registrars in Hobart on the weekend of 17 and 18 March 2012.
- Dr Rachael Nunan again conducted the Annual Registrar Selection Day, which in 2011 was accessible via teleconference. For the first time, two Victorian Registrars were unmatched, and all training positions, apart from the rural rotations, were filled. The promotion of rural training and rural practice remains a focus for the branch in 2012.
- The 2011 Annual Registrar Training Day was held at Epworth Health, organised by Dr Kerry O'Meara. This program and the RHM Training Day provide valuable added educational opportunities for our trainees.
- Dr Nathan Johns again represented Rehabilitation Medicine Training at the Annual Medical Careers Expo. He gave the branch committee feedback that there was increased interest over that of previous years.
- Dr Brian Anthonisz was unable to garner Registrar involvement in the Annual Registrar Research Presentation evening. This was disappointing but he presented a thought provoking audit of rehab LOS, and Dr Nguyen Le presented her research project.
- Dr Bill Stone has been awarded an RACP John Sands Medal for 2012.
- Dr Ajay Bharatula has been a strong advocate for trainees on our Branch Committee.

I wish to take this opportunity to thank the hard working Victorian/Tasmanian Branch Committee members. They unfailingly donate their time and considerable effort, to provide the Fellowship and trainees with quality educational activities and to promote Rehabilitation Medicine. I particularly wish to thank Drs Ronald Leong, Genevieve Kennedy and Michael Chou. Ronald has quietly and efficiently undertaken the large workload of Honorary Secretary without complaint. Genevieve has been a quiet driving force in negotiations with the Victorian Department of Health in considering funds to assist in training Victorian Rehabilitation Physicians. Michael carefully managed our dwindling funds, until the centralisation and amalgamation of the State branch budget to the RACP state office.

I wish to thank the departing members of the committee, Drs Nathan Johns, Rachael Nunan, Asha Matthews and Mohit Dhir, who have all positively contributed to the Branch Committee in many ways. I also particularly wish to thank Dr Ajay Bharatula, who contributed his trainee perspective and advocacy, which was greatly valued by the committee.

Mary Lou Leach

New South Wales & ACT

The Rehabilitation Redesign work continues within the NSW Ministry of Health. Reports are that the gap analysis is near completion and we await the outcome of that report. It is now confirmed that all redesign work within the Ministry will move to the Agency for Clinical Innovation (ACI). As part of these changes, ACI is being restructured. The branch has taken this opportunity to commence advocacy work with ACI in order to ensure that the full range of rehabilitation services is represented in the new ACI.

At the end of 2011 we held our annual trainee research presentation evening. It was great to hear the trainee projects and our congratulations go to Dr Nidhi Gupta who was awarded the prize of $200 for the best presentation.

Plans continue for the 2012 NSW/ACT CME weekend in the snow. Keep an eye out for more details very soon.

Finally, this will be my last report as Chair. I’d like to thank all the Fellows and trainees who have volunteered their time and expertise during my time as Chair. The willingness of you all to roll up your sleeves and pitch in to help makes the work of the branch possible.

Jennifer Mann
Rural & Remote SIG

The Rural and Remote SIG had another active year in 2012 with a series of teleconference journal clubs which were generally well attended.

The SIG thanks those Fellows who presented at teleconferences on behalf of other SIGs. There was particularly vigorous discussion around topics presented by Barb Hannon (MIND SIG) and Ian Cameron (Older Persons SIG).

Dates for journal clubs and business meetings are listed below.

Work on the new section of the Behavioural Sciences External Training Module 6, with questions addressing Rural, Remote and Culturally Appropriate Rehabilitation, was completed following a workshop in Sydney.

The Annual Dinner and AMM of the SIG was held in Brisbane on 14 September 2011 with 19 attendees. The SIG proposed the election of a non-medical member to the SIG for the first time, following approval of the Faculty Education Committee. All present voted in favour of the proposal to elect Sybil Cumming to membership and the invitation was accepted by her. Sybil has worked tirelessly for the SIG since its inception and her election is recognition of her contribution to the vitality of the group.

Jeremy Christley stepped down from the Chair’s position after six years. Jeremy is to be thanked for his excellent work as Chairman, his efforts have enabled the SIG to continue to provide support to Rehabilitation Physicians in isolated areas and he has been a strong advocate for rural health and rehabilitation issues.

David Murphy was elected Chairman, Gerry McLaren continues his role as Secretary, and Louis Baggio was welcomed to the Executive, joining Howard Flavell and Jeremy Christley.

The next AMM will be held in Melbourne on 17 May, during the World NeuroRehabilitation Conference. The venue is to be confirmed but will be close to the conference venue.

The SIG encourages all those Rehabilitation Physicians working outside of major metropolitan centres, and indeed any physician who works in a professionally isolated situation, to join in the activities of the SIG.

Journal Club 2012
1.30 pm fourth Friday in the month
- 24 February
- 27 April
- 22 June
- 24 August
- 23 November 2012.

Business Meetings 2012
1.30 pm third Friday in the month
- 16 March
- May – to coincide with Melbourne ASM World Congress NeuroRehabilitation
- 20 July
- 19 October.

David Murphy, Chairman
davidm1@iinet.net.au

New Zealand

Annual Members Meeting

The NZ Branch Annual Members Meeting was held in Wellington on Saturday 25 February, as a face-to-face meeting, and was attended by AFRM President Kari McCarthy and President-Elect Chris Pozos. Dr Cynthia Bennett was elected NZ Branch Chair. As part of the agenda the Branch reviewed the Draft NZ Rehabilitation Strategy, which is slowly progressing towards the next round of wider consultation.

Rehabilitation Medicine Symposium

Preceding the Annual Members Meeting a Rehabilitation Medicine Symposium was held at the Wellington School of Medicine, convened by Dr Will Taylor and open to all AFRM Fellows and trainees. This featured presentations by trainees and Fellows, as well as invited speakers including Dr Sara Dent, Research Fellow of the Injury Prevention Unit, University of Otago, Dr William Levack, Senior Lecturer in Rehabilitation, University of Otago, and A/Prof Chris Pozos who was recently appointed the founding Hammond Chair of Positive Ageing and Care at University of New South Wales.

Fellowship matters

The NZ Branch congratulates Dr Kathryn McPherson on being recently awarded Honorary Fellowship of the AFRM. Professor McPherson has held the Laura Ferguson Chair in Rehabilitation at AUT University in Auckland since 2004, where she is also Director of Person-centred Research in Rehabilitation and a member of the Health and Rehabilitation Institute. Dr McPherson has contributed to many New Zealand Rehabilitation Association conferences and AFRM Annual Members Meetings. The NZ Branch looks forward to many more valuable contributions she will make as an Honorary Fellow.

Training matters

NZ Training Coordinator, Dr Boris Mak, has facilitated weekly training sessions via video conference for NZ trainees, complemented by a number of exam preparations/mock OSCE sessions. The program is posted on the AFRM website, under the NZ Branch heading.

Yours sincerely
Dr Jurriaan de Groot FAFRM (RACP)
Chair, NZ Branch AFRM
International Classification of Functioning, Disability and Health SIG

I write this report in Sao Paulo where a few minutes ago I finished the last of a series of discussions in my role as chair of the ICF subcommittee of the WHO committee of the WHO. Sao Paulo organised a meeting for the implementation of the World Report on Disability, and in parallel the ISPRM held workshops for the ICF subcommittee and the subcommittee for the implementation of the WRD on disability.

Nenad Konstanjsek, of WHO, was present throughout the workshop and presented a review of development of ICD and introduced the major changes which will be included in the revision for ICD 11, emphasising the incorporation of functional properties for some health conditions. The President of ISPRM, Prof Gerold Stucki, introduced the importance of having fields on functioning included in ICD 11. The participants of the workshop then reviewed a list of top “100” health conditions, from WHO global list of disabilities and ranked the conditions relative to importance from rehabilitation perspective. Conditions not directly related to rehabilitation interventions were excluded. Additional conditions which the group felt were directly related to rehabilitation and not yet in the top “100” were added.

The next step will be to call for expert input via a published article and distribution through the national societies, to assist in the process of populating functional properties of the conditions related to rehabilitation.

Other matters discussed in the workshop included the need for a review of the granularity of ICF items and a plan to develop an ICF assessment and reporting tool.

There has been little coordinated activity of the ICF subcommittee otherwise.

Friedbert Kohler
2012

6 – 9 May
Brisbane Convention Centre, Brisbane, Australia. Website: www.racpcongress2012.com.au

12 – 13 May
Stroke Rehabilitation Research Satellite Meeting: Establishing Collaborations and Priorities in Clinical and Translational Stroke Rehabilitation Research. Crowne Plaza Hotel, Hunter Valley, New South Wales. email: alex@dcconferences.com.au Phone: +61 2 9954 4400

16 – 19 May
Innovations in NeuroRehabilitation, 7th World Congress of NeuroRehabilitation, in conjunction with 20th ASM of the AFRM & the 35th Annual Brain Impairment Congress for the Australian Society for the Study of Brain Impairment (ASSBI). Melbourne Convention and Exhibition Centre, Melbourne, Australia. Website: www.dcconferences.com.au/wcrn2012 Email: wcrn2012@dcconferences.com.au

16 – 19 May
24th Annual Meeting of European Academy of Childhood Disability.
Istanbul, Turkey. Website: www.eacd2012.org

20 – 23 May
3rd Conference of Asian-Oceanian Society of Physical and Rehabilitation Medicine, AOSPRM.
Bali, Indonesia. Email: aospbmbali@pharma-pro.com Website: aosprm2012.org

28 May – 1 June
3rd SpineWeek.
Amsterdam RAI Exhibition and Convention Centre, Amsterdam, Netherlands. Website: www.spineweek2012.com

27 May – 1 June
12th International Child Neurology Congress.
Brisbane, Australia. Website: www.iscnc2012.com

29 May – 1 June
18th European Congress on Physical & Rehabilitation Medicine, ESRPM.
Thessaloniki, Greece. Website: www.esrpm2012.eu

30 May – 2 June

17 – 21 June
16th International Congress of Parkinson’s Disease and Movement Disorders.
Dublin, Ireland. Website: www.movementdisorders.org/congress/congress12

27 – 31 August
14th World Congress on Pain, IASP.
Yokohama, Japan. Website: www.iasp-pain.org/Yokohama

2 – 6 October
14th World Congress on Pain, IASP.
Yokohama, Japan. Website: www.iasp-pain.org/Yokohama

10 – 13 October
8th World Stroke Congress, World Stroke Organisation.
Brasilia, Brazil. Website: www.kenes.com/stroke2012

10 – 13 October
4th International Cerebral Palsy Conference.
Pisa, Italy. Email: cp2012@meridianevents.it Website: www.cp2012.it

19 – 20 October

19 – 20 October
Spinal Bifida Masterclass - National Spina Bifida Conference.
Novotel, Sydney Olympic Park, Australia. Email: JulieD2@chw.edu.au

23 – 27 October
Dallas, USA. Email: www.spine.org

24 – 27 October
ANZSCoS 2012 Annual Scientific Meeting: SCI New Approaches and Challenges.

15 – 18 November
AAPM&R 2012 Annual Assembly & Technical Exhibition, American Academy of Physical Medicine & Rehabilitation.
Georgia World Congress Center, Atlanta, Georgia. Email: corporatesupport@aapmr.org

2013

4 – 7 February
14th World Congress, ISPO.
Hyderabad, India. Website: www.ispo.org

8 – 10 March
International Conference on Cerebral Palsy and Developmental Disabilities.
Lucknow, India. Website: www.indiancerebralpalsy.com

16 – 20 June
7th World Congress, ISPRM.
Beijing, China. Website: www.isprm2013.org

3 – 6 October
AAPM&R 2013 Annual Assembly & Technical Exhibition, American Academy of Physical Medicine & Rehabilitation.
Washington, DC. Website: www.aapmr.org

27 – 31 October
8th Interdisciplinary Congress on Low Back and Pelvic Pain.
Dubai. Website: www.worldcongresssbp.com

2014

13 – 16 November
San Diego, California. Website: www.aapmr.org

2015

6 – 11 June
8th World Congress, ISPRM.
Berlin, Germany. Website: www.isprm2015.org

1 – 4 October
Boston, MA. Website: www.aapmr.org
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Before prescribing, please review Approved Product Information available on request from Allergan.

Our eyes met. 2 tiny hands held. Many more hugs given and received. 4 glasses refilled, not spilt. 8 buttons buttoned on my favourite shirt. Steak sliced. 17 pairs of laces tied. 78 Christmas presents wrapped, every year. 1 physiotherapist, impressed. Countless dinners served. Endless channels surfed. Sacks of potatoes peeled. 3 hems sewn on favourite trousers. Smiles smiled. Greetings and farewells waved.