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Rhaïa

The Official Newsletter of the Australasian Faculty of Rehabilitation Medicine

The Royal Australasian College of Physicians

Special Paralympic Edition

Meet the Superhumans

Forget about everything that you thought you knew about strength... Forget everything you thought you knew about humans... It's time to do battle...

Ref: Channel 4 advertisement for Paralympics

Article by Ingrid McGaughey

My partner Michael and I decided four years ago that we would go to the Paralympics in London in 2012. It wasn't that we had a professional or personal relationship with any of the athletes. We had simply watched some of the Paralympics on television, and had been blown away by the competitors obvious tenacity, dedication and athleticism. In many ways their achievements seemed even more remarkable than those of the Olympians. (And the level of sportsmanship also seemed better!)

To put it in simplistic terms, I'm not, by any stretch of the imagination, a world-class athlete. But I know that even I could manage to:

- Swim 200 meters backstroke, and stay afloat for the duration,
- Stagger around the 800 metre runningtrack,
- Manage an inelegant leap over a lowish high jump,
- And kick a soccer ball in roughly the 'right' direction.

However I'm pretty sure that I would not manage:

- The 200m backstroke with no functional arms or legs without drowning,
- The energy expenditure of sprinting around the arena with a hemiplegic gait or even blindfolded at speed with a sighted co-runner advising me of hazards
- Hopping up to the high jump with one leg and launching myself over 1.6 metre bar,
- Or locate a tinkling. moving soccer ball while blindfolded, let alone kick it anywhere.

Photograph by Jagdish Maharaj (IAC photographic competition winner)

Yet at the Paralympics we saw this and more. And even we were surprised by just how much we enjoyed the Games...

My overwhelming impression was these games, over all others that had occurred before, were about respect for the achievements of world-class athletes. The pre games media coverage carried a definite message that the athletes weren't interested in pity, or being regarded as any way lesser to the Olympians. Basically the message was that these were THEIR games, and this was THEIR time.

We had been lucky with the ticket allocation. My sister was a resident of the UK and had put in for tickets in the initial ballot. In the end we received great tickets to almost every session we requested: two sessions of athletics, two of swimming, as well as the women's wheelchair basketball finals. We had missed out on the wheelchair rugby tickets much to my partner's disappointment, but through the Australian Paralympic Association 'follow my team' allocation had been fortunate to score guaranteed tickets to the wheelchair rugby finals series if Australia progressed that far. They did (and went on to win gold) so all in all seven sessions of world-class sport...not a bad haul.

Many of the Brits we met at the Games were amazed that we had managed to gain tickets to so many sessions. I think the difference was that we applied well before going to the Paralympics became desirable and sexy. The common story we heard from the locals was that people had applied for Olympics tickets, had missed out, and then decided to 'try' one or two Paralympic events, usually to see the infrastructure rather that the athletes per se.

But as the Olympics came and went, and the Paralympics approached, attitudes began to change.

Post Olympics, large billboards appeared in London and on Channel 4, the official UK broadcaster of the Paralympic Games. Supposedly addressed to the Olympians, they cheekily stated '...thanks for the warm up...'. The video footage can be viewed at http://www.youtube.com/watch?v=S48VDQGzCGk

Channel 4 launched a great publicity program all round. Another brilliant commercial entitled 'meet the superhumans' and featuring the hip-hop legends Public

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This Issue

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Editorial

Succession planning means different things to different people.

Perhaps we think immediately of the use of the term in professional healthcare settings. In our Faculty's structure, for example, we have a Past-President, President and President-elect. This is precisely so that the continuity of corporate knowledge and professional collegiality will continue, should (as our President said to me in jest the other month) one be hit by a bus, or be taken out by a sudden medical illness, as Gerry McLaren reminded us happens from time to time with hard working busy doctors in middle age.

At least the Faculty has rules around succession planning to ensure that it occurs, but I sometimes wonder how many of us (especially greying baby-boomers) really think purposefully about this in our individual professional lives? Do we need to keep on doing all the things with which we are presently individually involved; or could more tasks be shared with other colleagues as part of their planned professional and leadership skills development, preparing for the day that they can step up to the next level? Please don't misunderstand me; I am not speaking here of simple task delegation, but of a more complex sharing of experience and information, and inductively discussing some of the knotty non-clinical issues we might encounter. It seems to me that this sharing might happen naturally for many of us in reflective conversations with colleagues about complex patient care problems, but perhaps much less frequently with other administrative and non-clinical tasks.

With the current strong push from health service administrators (in NSW at least) for senior clinical staff members to reduce large outstanding leave balances immediately, (how) would your service cope if you were suddenly and strongly encouraged to apply for and soon take a couple of months of untaken annual or long service leave? Would (or should) the service look the same upon your return?

Right at the start of my time as a registrar thirty years ago, I was fortunate to have worked under Bob Oakeshott and Tom O'Neill, two of our Founding Fellows. After the first month with Bob, he upped stakes and moved to start a rehabilitation service somewhere that was quite hard to get to in the Persian Gulf called Abu Dhabi, leaving a couple of consultants to run things at the Royal Ryde Rehabilitation Hospital for two years, and I learned a lot of things from them very quickly indeed.

In the next term, a month after starting with Tom, when the tender lower North Shore R&G service plant was being pruned, divided and transplanted from the old Mater Public Hospital to RNSH and Greenwich Hospital, Tom vouchsafed me his detailed insights into what was going on at that time, and his reasoning and planning for dealing with the health service administrators involved. Some plans were subtle, from his experience as a rural Shire Councillor in Young, and others seemed to me to have come straight from his time as a Lancaster commander in Bomber Command during WW2. I learned much about matching strategy and planning to situations encountered.

Last month, in the course of the real estate transitions that one embarks upon once the offspring have finally mostly left home, my Better Half and I discovered that our legal colleagues have an entirely different take on succession planning. Put bluntly, it is their euphemism for managing your (legal) affairs and determining what needs to happen along the way to your inevitable demise (guardianship, powers of attorney) and ensuring the effect of your Will thereafter. Apart from reminding us that we all should have updated Wills, powers of attorney and guardianship in place (beware the bus or medical illness that does not take you out completely), it is a reminder that transitions come to us all, and it is for us to prepare for these as well as we are able.

This is my last piece as Editor of Rhaïa, and I trust I have prepared for this transition as best I have been able over the last couple of months. I look forward to Rhaïa's further development in years to come with keen anticipation. Please give my successor Gerry the same generous encouragement and support you have afforded me over the last decade.

Wishing you a happy Christmas and New Year holiday season,

Andrew Cole

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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(See disclaimer on pg 2 for editorial policy and letters)

President's Report

Is it time for change?

20 years from now you will be disappointed by the things you didn't do than by the one's you did. So throw off the bowlines. Sail away from the safe harbor. Catch the trade winds in your sails. Explore. Dream. Discover. - Mark Twain

As I write this today I am aware that it is the 40th anniversary of the 1972 Australian Federal election, remembered most for the election jingle with the oft repeated phrase: Its time. For those of you who want a walk down memory lane, or for the others who don't know what I am talking about, you can re-live the Gough Whitlam 1972 election campaign at:

http://www.youtube.com/watch?v=vqMCZBjvmD4&feature=related

While that time of change in 1972 marked the beginning of a number of tumultuous years in Australian politics (later we all learnt that Life wasn't meant to be easy!) it was also associated with the beginnings of key reforms to the Australian health care system which saw the birth of the Medicare System (Medibank in those early years) and also considerable recognition and funding for rehabilitation services. Is it time for our Faculty to now consider significant change to our training program for Fellowship?

There were two key strategic issues that AFRM Council discussed at its Annual Strategy Day, held 21st September this year. The first was whether we should consider moving to a single qualification within the RACP, and the second was the AFRM's ability to engage in successful advocacy within the structure of the College. I am going to leave the second issue for now – and will cover it fully in the next issue of Rhaïa.

What is a single qualification and why would it be an issue?

As you all know, Fellowship of the AFRM is achieved through a training program independent of the FRACP – a situation that has existed since the establishment of the Australasian College of Rehabilitation Medicine (ACRM), well before the ACRM became the AFRM when it joined the Physicians College in 1993.

At that time it was suggested that over time consideration be given to integration of our training program with that of the other subspecialty systems within the RACP. Ten years have now passed and AFRM Council is reviewing its stance. Under a single fellowship model, Adult Rehabilitation Medicine would become an advanced training program within the FRACP, and Rehabilitation Physicians would be awarded an FRACP, not an FAFRM (RACP). Candidates would be required to undertake basic physician training, and the Faculty would continue to be the arbiter of the advanced training in Rehabilitation Medicine (as is the case with our current Paediatric Rehabilitation Medicine program).

In thinking about our training program we need to look to the future and ask:

What is the best model for Rehabilitation Medicine training 5, 10 and 20 years from now?
How should Rehabilitation Physicians be equipped for the health system of the future?

We all know that Rehabilitation Medicine is different from acute medicine, requiring a much more diverse outlook, but even so, *is it time to review our training pathway?*

What are the potential drivers for change?

The health system (at least the hospital end) has become more 'acute' in the past decade, marked by pressure to reduce length of stay in acute care and by the development of new models of care such as acute stroke units and orthogeriatric care. There has also been a greater focus on chronic care, including ongoing medical care of people with a complex array of co-morbid conditions and age-related change. The focus of bodies such as Health Workforce Australia is to improve workforce productivity and the breaking down of silos of care has become one of their aims.

We have seen our specialty respond by developing models of earlier rehabilitation medicine input to acute care and participation in shared care arrangements with other specialties. But is this enough? Are the days of waiting for patients to achieve optimal medical stability before they are transferred to rehabilitation units numbered? Are we equipping our trainees with the skills to optimally manage co-morbid medical conditions?

We also need to ask whether Rehabilitation Medicine Physicians are missing out to other specialties because we are not seeking out acute care or internal medicine roles because we are not 'credentialed' for that work. This might be especially relevant in smaller hospitals and in hospitals in rural areas. It may also become more relevant into the future, with aged care and chronic disease management likely to be some of the few real growth areas going forward.

Completion of the basic physician training program provides exposure to internal medicine as well as the opportunity for credentialing in acute care medicine (once, of course, advanced training in a subspecialty is completed and an FRACP has been awarded). It could be argued that basic physician training with advanced training in Rehabilitation Medicine, resulting in an FRACP, will provide our Fellows with more rounded internal medicine training, and allow them to compete with other physicians who hold the FRACP. It will also allow Rehabilitation Physicians to develop models of care which don't rely so much on other specialties.

What have been the issues with basic physician training in the past?

In the past, the arguments against adopting the basic physician training program for Rehabilitation Medicine have included:

- Rehabilitation Medicine won't attract enough trainees if trainees have to do basic physician training first. Arguments have been that the FRACP exam is too unpredictable, and trainees don't want to do the hours and overtime required for basic training;
- Restricting candidate eligibility to basic medicine trainees may discourage the people with a surgical interest;
- We will get the wrong type of doctors wanting to do Rehabilitation Medicine;
- Rehabilitation Physicians don't work in acute medicine;
- Our modules 1 and 2 are broader than just internal medicine;

- We have a rigorous exit exam to ensure competency, and the FRACP does not.

In addressing these concerns, we need to consider the following:

- The number of medical graduates will double in about a 5 year period. As it is not possible for the number of training positions to double, there will be more competition for specialist training positions, including Rehabilitation Medicine;
- The FRACP examination has become much more predictable, with pass rates comparable now to those of the FAFRM;
- The increased number of medical graduates and safe work hours means that the onerous hours once worked by basic physician trainees is a thing of the past, and trainees undertaking basic physician training are now well supported;
- Medical student selection has changed dramatically over the past decade, with a greater emphasis on selection by interview and the need for doctors to be more rounded in their views and interests;
- Health reform emphasis on flow of hospital patients has shifted priorities and Rehabilitation Medicine is now being asked to become involved earlier in acute care, before patients have become medically stable, and to provide ongoing care for chronic medical conditions;
- While our training program (including our Modules 1 and 2) involves more than just internal medicine, we could cover those parts missing from the basic physician training curriculum in advanced training for Rehabilitation Medicine;
- We can still choose to have an exit exam if Rehabilitation Medicine was an advanced training program. In fact, an exit exam for subspecialties is likely to become more common.

Where to from here?

Any change of this magnitude will require a great deal of thought, planning and consideration of all the issues, as well as broad consultation within the Fellowship and amongst trainees. There will be a lot of questions raised, including: *what would happen to existing Fellows? What would be the transition arrangements? How successful will our current unit directors be in negotiating for basic physician trainees to occupy our current SRMO/registrar posts?*

Please be assured that Council will take a very considered approach to this matter, with one of the first steps being to map the current AFRM training program against basic physician training. The plan will be to prepare a paper for circulation within the next year which will outline the issues in more detail and present the case for change. Our goal is to look to the future of the specialty of Rehabilitation Medicine, while also meeting the needs of existing Fellows and trainees.

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Now on to a few other matters.....

New Zealand

Thanks to Cynthia Bennett, Chair of the NZ Branch, I can report that the NZ Branch is continuing to be involved in the development of a National Rehabilitation Strategy for New Zealand, which is part of Work Force NZ and the Ministry. Our colleagues across the Tasman are also working on a National Spinal Strategy, which will follow the patient from injury and emergency care through to rehabilitation and ongoing support in the community.

Planning is also well underway for the 2013 NZ Rehabilitation Symposium where registrars are required, and consultants highly encouraged, to present. The 2013 Symposium will see the commencement of the *Dr Boris Mak Rehabilitation Trainee Award* for best presentation, an award honouring Boris, whose untimely death occurred earlier this year.

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Changes for Rhaïa

Still on the topic of change, I outlined in a recent E-Bulletin some possible changes to Rhaïa that Council is considering. In short, these could include:

- Introducing a peer-reviewed section (e.g. for short papers about the status of rehabilitation medicine in Australia and New Zealand, topical issues and models of care)
- Having an editorial panel to peer-review these short papers
- Moving routine branch and committee reports out of Rhaïa to the AFRM website
- Making Rhaïa more clinically focused – especially for trainees
- Moving to an e-format
- A possible name change

Having mentioned Rhaïa, I would also like to take this opportunity, on behalf of Fellows and trainees, to thank Andrew Cole, who is stepping down as long time Rhaïa Editor. Thanks Andrew for a great job! New Chief Editor Gerry McLaren takes over in 2013. Welcome into the role Gerry.

Chris Poulos

AFRM Annual Scientific meeting 2013

The 21st AFRM ASM will be held in Sydney on 18—20 September 2013

The theme of the Meeting will be 'On the Move'

Pre and post conference workshops will be held on 17 September and 21 September

Venue and cost details will be included in forthcoming editions of the e-bulletin.

Rhaïa

How do you pronounce it and what does it mean?

Rhaïa is derived from the ancient Greek verb Rhaidzein meaning 'to find relief' or 'recover from illness'.

Rhaïa is pronounced 'Ray-ah'.

Continued from front page

Enemy can be viewed at http://www.news.com.au/national/the-superhuman-sports-heroes-set-to-storm-london/story-fndo4eg9-1226459085129

The video was at times sobering especially when viewing the footage of a fetal ultrasound with the words 'I'm sorry' softly in the background, a traffic accident and an explosive device being detonated in a warzone. These events highlighted that an alteration in activity and subsequent participation can affect absolutely anyone.

However, the bulk of the video is empowering – the featured Paralympians look honed, svelte, pumped, and above all, in control. Public transport was also peppered with signage featuring British Paralympians with the slogan '...meet the superhumans...' Previously British airways print media advertisements had encouraged Londoners to travel abroad during the Olympics, now they suggested '...come back home and support the Paralympians...'

Several British Paralympians achieved celebrity status, being featured in gossip magazines, commercials and widely distributed media interviews. The Paralympics, as had the Olympics, featured an arts program, but this time displaying other facets of 'ability'. The National Portrait gallery hosted a fabulous photography exhibition featuring preparation of both Olympians and Paralympians. There were other art exhibitions, theatre, ballet, and comedy showcasing people who had clearly dropped the 'dis' from disability.

It all added up to a totally different feel. No longer were the Paralympics the Games which were treated almost as an afterthought and would be attended by athletes relatives, a few interested spectators and a slew of compulsory school excursions.

Instead they were a hot topic! When we told people we had come over specifically for the Paralympics they were surprised...but also interested, and often (especially as the games progressed and public interest grew) frankly envious.

Certainly the Brits got right behind the Paralympics. Almost all events were sell outs (although sadly there were still many vacant seats in media and official guests sections). The atmosphere was generous, heartwarming and generally pumped. Several events in particular stay in my mind:

- The (predominantly) British crowd collectively leaping to its feet and fist pumping the air as David 'Werewolf' Weir powered to victory in the 1500 metres T54 (Athletes with normal upper limb function with partial or normal trunk function, fair to normal sitting balance and no lower limb function) category. The footage can be viewed at http://www.youtube.com/watch?v=NDrnBDLpcOM&feature=related. We also were lucky enough to see Kurt Fernley in the same race.

- The men's 5000 meters T11 category (Athletes in this category will generally have some residual sight, the ability to recognize the shape of a hand at a distance of 2 meters and the ability to perceive clearly will be no more than 2/60). It was won by a fabulous Moroccan runner who powered home in a world record time of 13.53.76. (Olympic time is 12.37.35)

- But the great part was an 'Eric the Eel' moment. While the field was generally applauded, the biggest applause was reserved for the last, blindfolded runner who was lapped 3 or 4 times by the leaders. A Mexican wave of cheering literally followed this last runner round and round the arena until he finished to a deafening roar. The runner just had this wonderful smile on his face, and I thought that pretty much summed up the prevailing mood of the games.

- Watching Matt Cowdrey and Ellie Cole (both S9 category) storm home for gold in the pool. And parochial me leaning over the balustrade flapping my oversized Australian flag shrieking ''good onya..' before asking for a photograph (such a yobbish groupie, the Paralympics tends to do that to people...) I was also particularly impressed by Esther Overton, the only S1 (the most severely impaired) category swimmer in the S2 50 metres backstroke finals race. She didn't medal and seemed really tired and disappointed afterwards – I only wish I'd had the opportunity to tell her how wonderful her swim was.

- The crowd laughing with the gold medal swimmer in the S14 (intellectual disability) category who, unable to contain his excitement at winning, gleefully snatched the presentation flowers off the tray and blew extravagant and joyous kisses to all and sundry including the slightly dumbstruck guest presenter.

- A sea of Australian flags and green and gold supporting the Australian women's basketball team in the Gold medal finals.

- Sitting beside Ryley Batt's dad and receiving a comprehensive lesson in wheelchair rugby rules and tactics (Ryley is considered the greatest player in wheelchair rugby in the world, and having watched Australia play against Japan and Canada, as well as a slew of other matches I can well believe it...an unbelievable display of wheelchair maneuverability and teamwork).

- The Brits themselves –always welcoming and chatty and happy to wave an Australian flag when there wasn't a Brit in the competition.

- And finally the volunteers who did an awesome job looking after us all.

So has the respect for the Paralympians translated into better respect for all people with perceived disabilities? It's probably too early to tell, but I suspect probably not. The hype centered on elite athletes, and I suspect that while their general image has improved, people will differentiate between the Paralympic athletes and the relatively unrecognised majority.

However, shows like the 4th Leg by Australian comedian Adam Hills, which featured each night on Channel 4 during the Paralympics and were a huge ratings success, did much to break down stereotypes about the abilities of people with various impairments. The Guardian newspaper summed the show up nicely with '...The Last Leg: often tasteless, sometimes awkward, always funny...' and mused that the show had 'found exactly the right brand of edgy humour to break down barriers over disability'.

The Paralympics and associated events certainly broadened my thinking...

I suspect it will be harder for us to source tickets for Rio in 2016, but we intend to try and get tickets to that, but I'd like to branch out and explore some different events this time around. And maybe, just maybe, the wheelchair rugby championships... It's safe to say we are hooked!

Ingrid McGaughey

My times with Paralympic and Olympic Movements

Paralympic Games

The Paralympic Games is a major international multi-sport elite event for athletes with a disability. The broad categories of disability groups that participate at the Paralympic Games are Amputee, Cerebral Palsy, Intellectual Disability, Les Autres, (meaning others), Wheelchair Athlete, and Visual Impairment. The Games began in 1948 as the International Wheelchair Games when on the day of the opening of Summer Olympics in London Dr Ludwig Guttman of Stoke Mandeville Hospital hosted a sports competition for British WW II veteran patients with spinal injury. At this stage the Paralympic sport was regarded as an extension of medical rehabilitation. Four years later in 1952 Dutch veterans took part alongside the British, making it the first international competition of its kind. However, the first 'Paralympic Games' took place in Rome in 1960 with 23 countries and 400 athletes. It wasn't until 1988 when the first true linked modern Paralympic Games was held in the same venue as the Olympic Games in Seoul, South Korea. Since Sydney 2000 Paralympic Games there has been an exponential growth with an increasing number of countries and athletes participating with a growing worldwide media coverage and audience.

As the Paralympic Movement evolved the organisation to govern these games at global level also evolved. In 1964 the International Sports Organization for the Disabled (ISOD) was established. In 1982 the International Coordinating Committee of World Sports Organizations for the Disabled (ICC) was formed as a precursor to create the International Paralympic Committee (IPC). In 1989 the Games governing body, IPC was established patterned on the five International Olympic Committee (IOC) global regions. This lead to the dissolution for Far East South Pacific (FESPIC) Games Federation for the Disabled which consisted of Asia and Oceania countries. In 2001 IOC and IPC signed an agreement which guaranteed that host cities would be contracted to manage both the Olympic and Paralympic Games. This agreement has, this year, just been extended to 2020.

I attended the London 2012 Paralympic Games as an IPC International Classifier for Shooting. As such I was an International Technical Official (ITO) working for the London Games Organising Committee (LOCOG) (Classification is not a paid job). My experience at this Games was very different compared to my previous involvements with Olympics as Team Physician to Seoul 1988 Olympics; Barcelona 1992 Olympics; Salt Lake City 2002 Winter Olympics and Paralympic Games in different capacities representing Fiji as Team Physician and Assistant Chef de Mission, Atlanta 1996 Paralympic Games; Chef de Mission, Sydney 2000 Paralympic Games; Team Physician, Athens 2004 Paralympic Games; and Beijing 2008 Paralympic Games.

As the Classifiers need to arrive some days prior to the actual start of competition of their sport, I arrived into London Heathrow very early on the morning of Saturday 25th August 2012, clear four days prior to the opening ceremony. On arrival with other colleagues, we were whisked through the Immigration and Customs arrival procedures and driven by a bus across the city to the East side of London Games Village. Passage through high security and check-in into the Village into the 'Technical Officials Block' went smoothly followed by self orientation of the very large purpose-built Games Village. Later the same day I met up with my Classification team made up of a Head Classifier and two other Classifiers – one each from South Korea and Norway. The first task on the second day was to inspect the Shooting venue and meet up with the sport manager in preparation for classification.

Iliesa Delana of Fiji celebrating Gold medal win in F42 High Jump

What is Paralympic Classification?

Athletes with a disability must have a sport classification to be eligible to participate in any competitive international Paralympic sport. As has the Paralympic Movement evolved over the years so has the Paralympic sport classification system.

"Classification is an assessment process, which group athletes whose impairments (ability) causes similar limitations in a particular sport in order to allow for meaningful and fair competition". IPC

The Classification system differs from sport to sport and has two important roles: determines eligibility to compete in a particular Paralympic sport - known as the minimum disability criteria (MDC); and groups athletes for competition.

There were 23 summer sports held at London 2012 Paralympic Games with each sport having different requirements for classification in-terms of MDC and the number of athletes to be classified at the Paralympic Games.

23 Summer Sports held at London 2012 Paralympic Games

Archery	Goalball	Rowing	Wheelchair basketball
Athletics	Judo	Sailing	Wheelchair Dance
Boccia	Para-Canoe	Shooting	Wheelchair Fencing
Equestrian	Para-Cycling	Sitting Volleyball	Wheelchair Rugby
Football 5-a-side	Para-Triathlon	Swimming	Wheelchair Tennis
Football 7-a-side	Powerlifting	Para-Table Tennis	

As Shooting had extensive pre-Games classification activities at various World Cups and international competitions there were no shooters to be classified per-se. However, there were many who required a confirmation of their class and re-issue of Classification Cards for those who did not bring or had lost their cards. Thus much time was spent assisting the Jury personnel with equipment checks and measurements of the visible trunk above the wheelchair backrests allowed for different Classes of shooters. During the official training and competition sessions Classifiers observed the athlete for conforming with the Class profile already allocated and attended to any related queries that arose.

Other activities

During the grand opening ceremony I got to sit with other colleagues in the Officials stand and watch the 'parade of the nations' and the gala production rather than being part of the 'parade' as in all my previous involvements. The opening ceremony turned out to involve Handel's Eternal Source of Light Divine to 1948 Universal Declaration of Human Rights to apple falling in Isaac Newton's Lincolnshire garden to Stephen Hawking's celebration of the Higgs particle. The 80,000 capacity packed Stratford stadium audience stayed the longish parade of nations and the production till the fireworks punctuated the end of the ceremony after midnight.

Apart from my 'technical' Classifier role in the Paralympic Movement I have been involved with development of Paralympic sports and athletes in Fiji and the Oceania region. Being a Board member of the Oceania Paralympic Committee I had dual accreditation with the privilege to access other sports and facilities to meet and support Oceania teams and athletes. Again being an ITO it was not entirely feasible to perform the secondary role but it was extremely kind of IPC to allow the dual accreditation. As an ITO I found that there were restrictions as I could not access certain general athlete entertainment areas to be with them. The huge dining complex had an area roped out for ITOs only indicating either athletes or ITOs were not allowed to mix with each other during their meals although there were numerous cross contaminations!

As the countries arrive at the Village and are scheduled they have a welcoming and flag raising ceremony at the Village Plaza conducted by the Village Mayor. During all my previous involvements I was part of the nation being welcomed but this time as an ITO I watched a few of these ceremonies from the sideline as the Village Mayor, daughter of Dr Ludwig Guttman, Eva Loeffler rightfully repeatedly reminded each nation of her connections with the beginnings of Paralympic Games and it's place (in history - some programs still promote sports) in medical rehabilitation.

It was a reminiscent of my work in Fiji where I was a member of a committee that started Annual National Games and Activity Day for the Disabled in 1984 – the year the medical rehabilitation hospital and services was formally established in Fiji. This Game was a precursor to the Fiji Paralympic Committee of which I was the founding President for 13 years from 1990 - 2003. The Annual National Games and Activity Day for the Disabled in Fiji has continued to be an annual event ever since. This event had given me the opportunity to select and develop elite athletes for international events. One day, in the early 1990's, a young primary school student from a village some 150 km away came to my Amputee Clinic for prosthetic assessment. After the assessment I invited Iliesa Delana to come to our national games which he eventually did and got into the elite development mode. Through continued development opportunities we provided, Iliesa, an above knee amputee participating in Class F42 High Jump event at London 2012 Paralympic Games, became the first ever athlete from all the South Pacific countries to win a Gold medal in an Olympic or Paralympic event. (See photo page 7). He obviously became a legend overnight and a huge success story for the Fiji Paralympic Movement. Personally I have been involved with the movement in Fiji since 1984 and it was pleasing and very satisfying for me to see Iliesa accomplish any Paralympian's dream!

Overall, London 2012 Paralympic Games was very well organised and executed with excellent village and games facilities and logistics. It was a tremendous experience to be part of it from the opening ceremony spotlighting the role of science in helping to change social attitudes, Guttman's vision of 'transforming a severely disabled patient into a taxpayer' to the Paralympic Movement continuing to be 'Spirit in Motion' in changing public perception not just of disabled athletes but of disability in general; to witnessing a Fiji athlete, being first ever in the South Pacific to win a Gold medal at the Games.

Jagdish Maharaj
IPC International Classifier for Athletics and Shooting
Director Finance, Oceania Paralympic Committee
Founding President, Fiji Paralympic Committee

Australian Women's Basketball

I had attended the ISCoS AGM in London and had been trying frantically to get tickets on-line for any of the Paralympic events without success. My luck changed when our very good friend arranged for four of us to be admitted as guests of the London Olympics Organising Committee (LOCOG) to the North Greenwich Arena to watch the women's wheelchair basketball semi-final match between Australia and USA.

It was an exciting match and The Gliders (Australian team) won narrowly.

We were courtside and could get up close to the play. I also managed to run into Troy Sachs (pictured) who was one of Australia's top men's wheelchair basketball players in the Sydney 2000 Paralympics when I was a volunteer Medical Venue Manager at the Superdome. Troy is now coaching a couple of the current women players. Also barracking at courtside was Gerry Hewson, another former Australian men's wheelchair basketballer and coach.

It was great to be there with the enthusiastic audience enjoying the high achievers in wheelchairs.

Susan Rutkowski with Troy Sachs (Australian Women's Basketball)

Paralympics – Nazim Erdem

Nazim Erdem is the oldest and most experienced player on the Australian wheelchair rugby team. With three Paralympic Games and two silver medals behind him, Nazim is striving to win the long-awaited gold medal missing from his collection.

Growing up, Nazim had a quirky habit of timing how long he could hold his breath. He became so good; he could hold it for up to three minutes. Then at 20, a lifetime of practice saved his life when he dived off a pier into shallow water and broke his neck. He couldn't move his body, his mates thought he was mucking around and facing the prospect of drowning, he held his breath. It was two and a half minutes before he was pulled from the water.

Prior to his accident, Nazim was an amateur boxer and played local AFL football. In 1992, he started playing wheelchair rugby and in 1998 made his debut on the Australian team at the world championships.

Choosing wheelchair rugby for its 'roughness,' Nazim is an adrenaline junkie and loves adventure. On the rugby court, he has a 0.5 classification, which means he is a key defender on the team.

Away from the rugby court, Nazim became the first person with a spinal cord injury to complete the Targa Tasmania, a six day car race around Tasmania, in which he finished third in his group and in 2002 he became the first person with a spinal cord injury to paraglide solo. He even tried to jump his wheelchair up a gutter, similar to a skateboarder but instead fell out, which he believes is his most embarrassing moment to date.

Nazim also collects stamps, loves cars and admires Muhammad Ali for his determination to succeed despite the odds.

He has a diploma in computer programming and works as an information and peer support coordinator for a disability service and support organisation in Victoria.

Naz and Peter New
(Biography taken from internet)

Stephen O'Flaherty MB ChB FRACP FAFRM

(Retired effective from 2nd November 2012)

Dr Stephen O'Flaherty

After 35 years in paediatrics and 25 of these years in Paediatric Rehabilitation, Dr Stephen O'Flaherty has decided to retire. Early goals in his career were to have a consultant job by 30 years of age and retire at 60 years of age; both of these he achieved but significantly more in between. His medical training was in Otago NZ, followed by paediatric training at Sydney Children's Hospital, then known as the POW Children's Hospital (*I recall happy times working together as an RMO3 at Sutherland Hospital, when Stephen was doing registrar training there – Ed*). His first consultant paediatric position was in Western Sydney and at Westmead Hospital. Whilst at Westmead he became interested in providing a better service for children with cerebral palsy and acquired SCI and brain injury. As a result the Westmead Paediatric Rehabilitation Service began with Steve as the head of Paediatric Rehabilitation from 1989 to 1995.

The new hospital and move of The Royal Alexandra Hospital for Children from Camperdown to the Westmead site led to the amalgamation of the paediatric rehabilitation teams from Westmead and Camperdown. Steve was the inaugural head of Kids Rehab at the New Children's Hospital at Westmead from 1995 until his recent retirement in late 2012. During this period of time he led a dynamic group of clinicians and researchers. He developed many services for children with physical and cognitive impairments. Of note has been the development of a comprehensive Kids Rehab spasticity management program including using botulinum toxin injections, intrathecal baclofen pumps and selective dorsal rhizotomy. More recently he has been involved in the development of treatments for dystonia including multidisciplinary clinics and ITB. A research project with the WMH adult neurology department using deep brain stimulation for dystonic cerebral palsy is an ongoing project between the two units together with neurosurgery involvement. A career-long ambition has been the development of a comprehensive service for kids with movement disorders like cerebral palsy. The CP orthopaedic services have been strongly supported by Steve and with the recent relocation of the NSW Paediatric Gait laboratory to the Children's Hospital at Westmead the last piece of the comprehensive treatment program has finally become a reality.

Steve has published widely on paediatric rehabilitation and has been an examiner for both the RACP and the AFRM. He has been an active member of the Paediatric Rehabilitation SIG. Steve is well known and respected both nationally and internationally for training, particularly in the area of spasticity management - botulinum toxin treatments and the use of ultrasound guided injections.

All this he achieved whilst having a busy clinical program and running a large department with many clinical streams.

Steve has also been instrumental in establishing the very successful Emerald Ball: an annual charity fundraising Ball for the Kids Rehab department, now into its 12 year. The Emerald Ball was one of Australia's three finalists in 2011 for the Australian Events Awards – something of which Steve, the organising committee and Tess Assaad (event co-ordinator) should be very proud.

Colleagues and former trainees of SOF from left to right : Dr Ee Wei Lim NZ, Dr Kate Hall NZ, Dr Maria Kyriagis NSW, Dr Jenny Ault NSW, Dr Anna Ward NSW, Dr James Rice SA, Dr Kathryn Edward NZ, Dr Mary-Clare Waugh NSW, Dr Stephen O'Flahety NSW, Dr Adam Scheinberg Vic, Dr Ray Russo SA, Dr Antoinette Botman NSW.

Steve also has a very big love and commitment to his family and maintained a work life balance that is an example to us all. In 2009 the tragic death of his son Liam left the O'Flaherty family (his wife Jilly, daughter Jess and son Sam) devastated. With his family's support Steve returned to work and maintained his enthusiasm for the high standard of care of his staff and the kids in the Kids Rehab Department. He then established an ongoing trust fund to assist with ongoing education and training within the department in honour of Liam.

Steve's last day at work was 2nd November 2012, and was celebrated by an all-day symposium organised by Kids Rehab held at the Children Hospital at Westmead. The speakers included Steve's past and present colleagues, and they came from all over Australia and New Zealand. The program included a review of the unique nature of paediatric rehabilitation teams by Ms Lynn McCartney (including a very moving film tribute to Steve produced by Lynn), the evolution of paediatric rehabilitation in Australia by A/Prof Ben Maroszeky, constraint induced therapy by Dr Margaret Wallen, the neglected upper limb and botulinum toxin treatment by Dr Ray Russo, Orthopaedic Surgery in CP by Dr Paulo Selber, Neurology of Dystonia by Dr Paddy Grattan-Smith, management of Dystonia by Dr James Rice, Service Development in NZ by Dr Ee Wei Lim and the current status of the Victorian Paediatric Rehabilitation Service by A/Prof Adam Scheinberg. The day was a great success and very well attended by colleagues and clinicians from all over Australia. All felt that it was a fitting tribute to a man who has had widespread influence in paediatric rehabilitation in Australia and New Zealand, as well as UK and Asia.

Steve is greatly respected by his friends, colleagues and patients. His leadership, clinical skills and humour will be greatly missed in Kids Rehab. We wish him well with his next goal of reducing his golfing handicap, spending more time with his family and friends and wearing out his frequent flyer card.

All the best Steve!

Mary-Clare Waugh
Acting Head Kids Rehab
The Children's Hospital at Westmead

CONGRATULATIONS TO DR JAYANTHINI GANESHKUMAR ON WINNING THE IPSEN AWARD FOR 2012

ROUTINE SCREENING FOR HYPOPITUITARISM FOLLOWING SEVERE TRAUMATIC BRAIN INJURY: IS THIS ESSENTIAL?

J. Ganeshkumar, S. Browne, C. King

Brain Injury Unit, Royal Rehabilitation Centre Sydney, NSW, Australia.

Background: Hypopituitarism is defined as either partial or complete deficiency of anterior or posterior pituitary hormones. Traumatic Brain Injury (TBI) poses significant risk of hypothalamic and pituitary insult, with previous studies reporting pituitary dysfunction in up to 50% of patients. Many symptoms of hypopituitarism are similar to symptoms of severe TBI, eg: fatigue, mood disturbance, memory loss, impaired concentration, irritability and insomnia. Hypopituitarism can compromise a patient's sense of well being and overall quality of life. Failure to identify hypopituitarism could adversely affect a patient's ability to adapt physically and mentally after TBI. Consensus Guidelines on screening for hypopituitarism following TBI were developed to prevent undetected hypopituitarism.

Aim: The current study aimed to assess the incidence of altered hormonal levels secondary to hypopituitarism in a sample of severe TBI patients undergoing inpatient rehabilitation in a specialised Sydney Brain Injury Unit.

Methods: Consecutive series of inpatients underwent pituitary hormonal screening within a 3 month period. The blood tests performed were those recommended in the consensus guidelines. They were: Serum Cortisol (Morning), Thyroid Function Tests TFT (FT3/FT4/TSH), Insulin-Like Growth Factor (IGF1), Gonadotropins (FSH, LH), Testosterone /Estradiol and Prolactin

Results: Demographics of the 14 patients are presented in Table 1. The patterns of hormone results fell into three different groups:

I. Patients with all normal hormone levels;
II. Patients with at least one hormone below the normal range, indicating impaired pituitary secretion;
III. Patients with at least one hormone above the normal range, indicating excess secretion.

Table 1:

Total Number of Patients	14
Males	11 (79%)
Age Range	16-60
Median Age	24
Median time from injury	2.7 months
Type of Injury	
Motor Vehicle Accident (MVA)	64%
Fall	22%
Assault	14%

Prolactin is under inhibitory control, so impaired pituitary function results in an increase in serum concentration. The chance of detecting impaired pituitary function in our patient group is based on previous studies reporting overall 30% - 50% of incidence of TBI induced hypopituitarism.

In our study, only two patients had possible impaired pituitary function evidenced by high prolactin. In contrast, six patients had high gonadotropins. IGF1 was within the normal, age-specific range in all patients; serum cortisol was high in one patient; one patient had high TSH with normal T3 and T4.If we assume that 30% of the TBI population has impaired pituitary function, our findings of 2 patients with possible impaired pituitary function within the 14 patient group, fall within the limits of chance of detecting this condition.

If we assume that 50% of the TBI population has impaired pituitary function, our findings of only 2 patients with possible impaired pituitary function within the 14 patient group, are unexpected and statistically significant ($P<0.02$).The statistical technique used is the: Significance test of a single proportion.

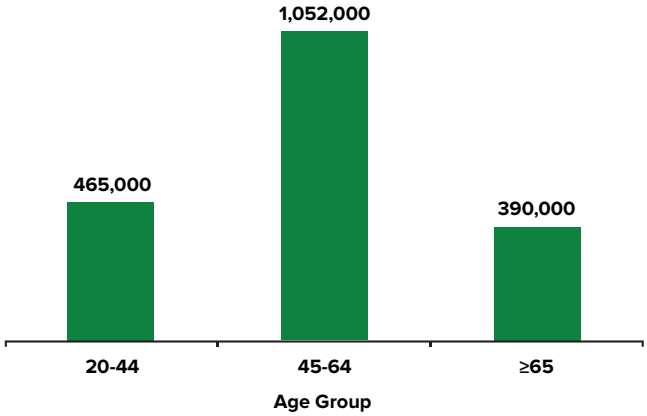
Discussion: Overall, the incidence of hypopituitarism in this pilot sample was less than expected from previous reports, if we assume 50% of the TBI population has impaired pituitary function. However, if we assume 30% of the TBI population has impaired pituitary function, our findings are consistent with previous reports. We found some hormone levels were more suggestive of peripheral failure rather than central failure from hypopituitarism - which is unexplained. The variation of the results from our study compared to previous reports may be due to many factors such as physiological factors, stress, concurrent illness, medications, variable time frame from initial injury to testing, variable age, variation in exact timing of the blood testing, and variable severity of brain injury in relation to post-traumatic amnesia duration.

Conclusion: It is essential to monitor for symptoms and signs of hypopituitarism following traumatic brain injury and perform hormone screening in line with the guidelines. Further research is indicated in the future with a larger sample and less confounding variables and long term follow up.

Reference: [1] E.Ghigo, B Masel, G Aimaretti, *Consensus Guidelines on Screening for Hypopituitarism following traumatic brain injury. Brain Injury,* 2005; 19(9): 711-724.
[2] R.J.Urban, P. Harris, B Masel, *Anterior Hypopituitarism following Traumatic Brain Injury. Brain Injury,* 2005; 19(5): 349-358.
[3] V.K.B Prabhakar, S.M. Shalet, *Aetiology. Diagnosis, and management of hypopituitarism in adult life.* Review Article, Post grad Med Journal 2006; 82: 259-266.

About 1.9 million people aged 20 years or older were newly diagnosed with diabetes in 2010 in the USA.

Estimated number of new cases of diagnosed diabetes among people aged 20 years or older, by age group, United States, 2010.



Source: 2007–2009 National Health Interview Survey estimates projected to year 2010.

[Source: Centre of Disease Control USA]

http://www.cdc.gov/diabetes/pubs/estimates11.htm#3

How much larger is your waistline?

Basmajian Prize

Congratulations to Dr Jasmine Gilchrist who is the 2012 winner of the 2012 Basmajian Prize.

The Faculty Education Committee is awarding a Merit Certificate and the 2012 Basmajian Prize for achieving the best performance in the Fellowship Clinical Examinations (adult) held on 11 August 2012. The prize also includes a cheque to the amount of $500 which will be awarded at the College Ceremony to be held in Perth, Western Australia on Sunday 26 May 2013.

Kleenex Neck

It helps to have a great relationship with your mother. When the chips are down it might mean even more.

Jacqueline lay on the bed unable to move. It was a new reality. She was unable to roll, unable to sit up, unable to move her legs and only one thumb worked. She could vocalise but there was no-one to hear her. Good time to think about your loved ones an hour away.

She lived on her own but had programmed her iPhone for speed dial. She could only move her thumb far enough to reach the first button. Her new boss Phil. She called but only got voice mail, “Don’t be concerned but I don’t think I’ll be at work today. I can’t seem to move my legs. I’ll call Mum and go to the doctors,” the message said. One advantage of country towns is that when Phil got the message he was soon at Jacqueline’s house.

Phil called out only to get a response of “I can’t seem to move.” He walked around the house looking for the best way in. “I’ll try and move to the back door,” Jacqueline yelled out. I can probably crawl to the laundry, she thought. As she tried to sit up and make her way to the back door she fell from the bed to the floor with a massive thud.

When Phil heard the thud he had no hesitation smashing a window and climbing in. The tears of relief in her eyes were justification enough.

When the ambulance arrived it was clear that there was a problem. Gorgeous young female prostate on the floor, in the presence of her boss claiming she was unable to move. The ED Department staff found it difficult to believe it was related to a sneeze.

Five days before she had parked her two door car, opened the door, moved the front seat forward and leant forward to retrieve her laptop. As you do. As she straightened up she sneezed. Immediately she felt a pain in the base of her shoulder blade.

The pain persisted and the next day she was fortunate to get an appointment with a new GP. He was confident that her recent onset pain was myofascial in nature. He organised an urgent appointment with a local physiotherapist. The diagnosis of myofascial neck pain was confirmed and dry acupuncture needling was the prescribed treatment.

Her neck pain however reached a crescendo over the subsequent few days. Jacqueline described it as a pinching pain radiating from her shoulder blade and down her arm. It forced her to leave work early and spend the next two days in bed. She sat on the edge of the bed and lay back, perhaps never to move again.

The ambulance staff provided verbal handover to the hospital nursing staff, who were very considerate The doctor examined Jacqueline in detail and said she would discuss it with her seniors. There were no clinical signs on examination. No reflexes, no spasticity, no movement. So to the verdict.

Jacqueline should go home and sleep it off. Stress from workplace disharmony often resolves after a good sleep. Jacqueline looked at the medical nursing team in disbelief but could not move her arms to strangle the doctor, let alone roll off the bed. An hour later her mum arrived. Mutual recognition syndrome.

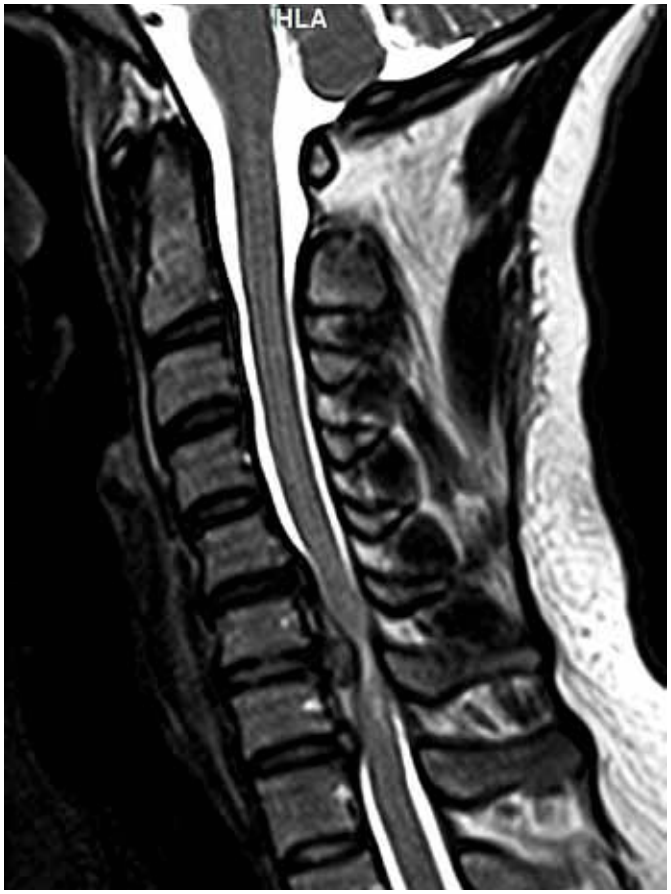
Mum worked in the office of a private radiologist in another city about an hour away. It was a long afternoon as the treating team

made no response to mum's clearly articulated suggestion.

"I think we should have an MRI."

The medical team reneged again. Please go home – we are tired and need the bed.

The thing about difficult mothers who care is that they never give up. Six hours after admission, the ED medical staff capitulated and ordered the maternally driven cervical MRI.

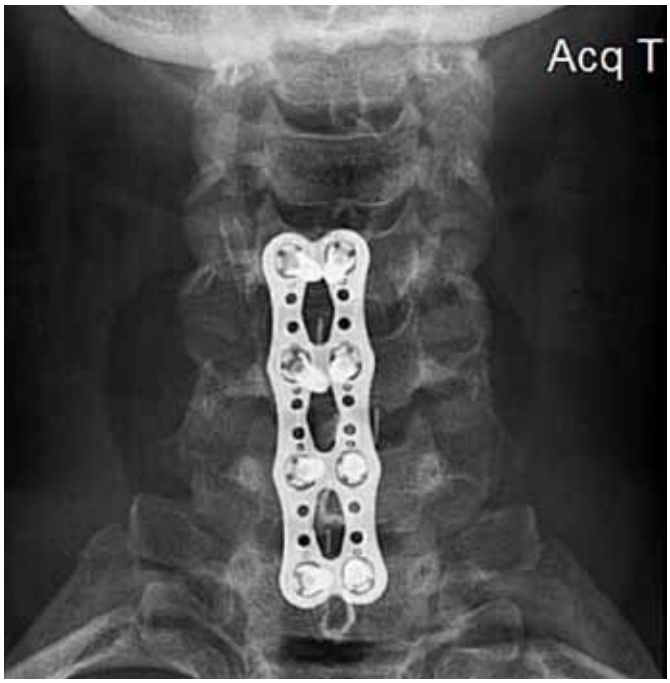


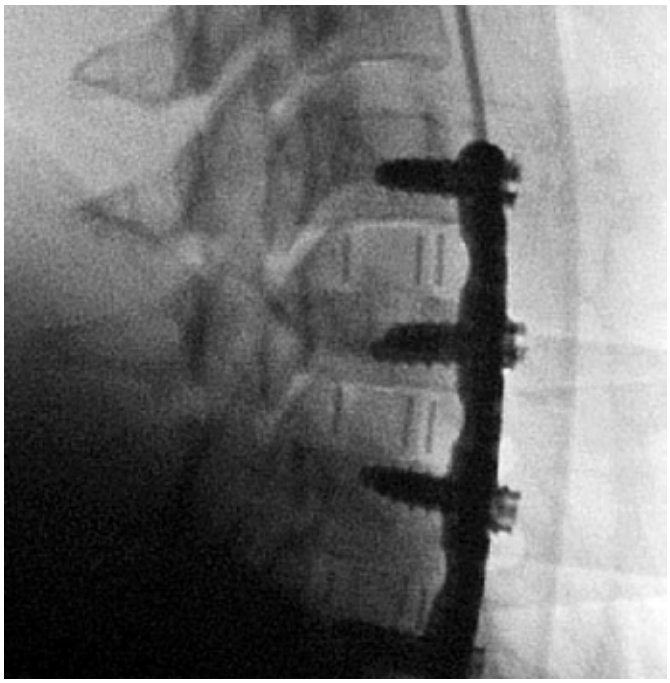
Quite a kerfuffle erupted. The state government had developed advanced electronic MRI imaging transmission from regional hospitals to the major city hospitals. The images developed a life of their own on the iPad of the neurosurgical registrar that evening. Unfortunately the fog and wind meant no helicopter could land near Jacqueline's bed. She was now in a cervical brace but it was a long slow trip to the big smoke. At 2 am, six days after her sneeze and fourteen hours after her ambulance trip, the neurosurgical consultant opened her neck. Five hours later they closed her neck wound over a metallic fusion from C3-7.

Happy Ending

Three months after surgery Jacqueline could walk unaided and only required her Aspen collar for car travel. She had high level balance problems and persistent numbness in C8 bilaterally. Hand dexterity was returning to normal. She had no neck pain. Her neurogenic bladder and bowel motor and sensory function had returned to normal. She was able to return to work, remotely at first using her mother's internet modem.

She is eternally grateful to her neurosurgical team. And her mother's persistence.





Lessons Learnt

- Never argue with a rampaging mother.
- Take the history carefully.
- If it does not add up, go back and take the history even more carefully.
- Absent reflexes is not consistent with functional disorder – consider spinal shock!
- Neurosurgeons are available via modem 24/7 and their intervention can restore neural function if you think and act quickly enough!

With thanks to the Neurosurgeons of Australia who work all night.

Gerry McLaren and Jacqueline Cherry

There are among us those who haply please
To think our business is to treat disease.
And all unknowingly lack this lesson still
'tis not the body, but the man is ill.
S. Weir Mitchell

I am a bit out of the loop at the moment as far as the training program goes. I have been on maternity leave for all of 2012, and will return to work in January to finish my final year of training. After completing the exams, I continue to learn a lot, but not about medical or rehab issues! So with this edition I give the floor to Dr Lucy Ramon, a senior trainee who has just completed the requirements of Fellowship. You will all be aware of the changes to the Administration and Management module, and Lucy was one of the first to attend a workshop. Administration and management is not something we have lot of exposure to as trainees, but it is vitally important when we begin working as consultants. So much so that I am considering doing a course, even though I have already completed the module. There is also an informative article about fitness to drive by Dr M. Abdul Vaseem.

Thank you to Lucy, Vaseem and all the other registrars who have contributed to the trainee section since its inception 3 years ago. The more of you who contribute the better, so please don't hesitate to send in your thoughts, reviews, case studies, study tips and photos to me at: jgil2726@gmp.usyd.edu.au.

Have a happy Christmas and safe New Year.

Jasmine Gilchrist

EXAMINATION FEEDBACK

Fellowship Written Examination - Essay Paper

The AFRM Fellowship Written Examination 2012 was held on 1st May 2012.

37 out of 40 candidates were successful in achieving a pass in the Essay Paper component of the Fellowship Written Examination.

There were five Modified Essay Questions and three Short Essay Questions.

As in previous years candidates performed significantly better in the Modified Essay questions than in the Short Essay Questions.

Short Essay Questions are designed to explore a candidate's ability to analyse a clinical situation and construct an organised and tailored response that indicates a degree of experience in the management of various clinical scenarios.

In general candidates who did less well in the Short Essay Questions often presented very generic information that did not reflect a depth of knowledge of the clinical scenario presented. Very few marks are allocated for generic information and marks are not allocated for details that are not relevant to the question asked.

It was indicated in the Instructions to Candidates that it was preferred that responses to the Short Essay Questions be given in point form. This should help to save you time and also allows the examiners to identify correct information more readily. There is a lot to answer in the time given so if you have practiced answering Short Essay Questions you will be better prepared.

It would be prudent to spend a little time at the start of the Exam reading through all the questions.

Please read all the questions very carefully and answer the questions asked.

Fellowship Clinical Examination (FCE)

The AFRM FCE was held at St Vincent's Hospital's Outpatient's Clinic in Melbourne on Saturday August 11, 2012.

With regard to candidate performance, feedback was obtained from the examiners regarding individual stations, as well as general comments regarding candidates' proficiency in the examination.

Key problem areas identified with candidates' performance in the FCE include the following:

- Candidates had a tendency to not answer the specific question being asked but rather responded broadly with generic responses.
- Candidates would benefit from practice in organising information and presenting answers in a cohesive and specific way that uses patient friendly language.
- **Specific knowledge deficits** were in the areas of:
  - Musculoskeletal X-ray interpretation
  - Joint examination proficiency
  - Return to driving recommendations
  - Fatigue management strategies
  - Return to sport after TBI
  - Practical management of urinary retention in the elderly
  - Gait analysis and footwear description
  - Capacity assessment and community support packages
  - Exercise prescription in pulmonary rehabilitation
  - Pharmacological interventions in patients with IHD

Module 1 Assessment

The Module 1 examinations were held in March and September this year with a total of 28 out of 43 candidates passing the assessments (pass rate of 65%).

The Module 1 exam consists of 100 multiple choice questions derived from the Faculty Question Bank.

The questions can be broadly divided into five major categories: Anatomy/Physiology (approximately 25%), Neurology (15-20%), Rheumatology (10%),

Internal Medicine - Respiratory, Endocrine, Cardiology, Infectious diseases, Geriatrics, Gastroenterology (25-30%) Clinical Sciences - Pathology, Haematology, Statistics, Genetics, Clinical Pharmacology, Immunology (15-20%).

Candidates continue to find the Anatomy/ Physiology components of the exam challenging as in previous years.

Candidates are encouraged to spend more time preparing for these components of the Module I examinations.

The Module 1 Sample paper available to assist candidates in preparation for this assessment is in the process of being updated to include more recent sample questions.

Module 2 Assessment

Candidates were examined across six clinical stations, four of which were “live” and two “static”.

Feedback from examiners indicated the following:

Communication Station: Most candidates were able to develop rapport but had difficulty staying on track with history taking. They need to be more factual in content when answering questions.

Cardiovascular physical examination techniques were generally poor. Many candidates were unable to smoothly and accurately perform a cardiovascular examination within the allocated time. There was a tendency to report signs that were not present. Candidates did better with ECG interpretation.

Neurological examination needs to be more targeted to achieve an accurate clinical diagnosis. A more organised approach is recommended for overall clinical examination and components of neurological examination such as gait and speech. Observed findings were often not interpreted accurately. There was also a tendency to report expected signs for that condition even if not actually present.

Musculoskeletal examination: candidates performed well on inspection and palpation but were poor with functional assessment. They will need to practice a systematic approach to ensure that they do not miss findings.

Static station: Poor performance in interpreting neuro-radiology, lack of familiarity with different types of cerebral imaging and unable to correctly identify structures, poor understanding of neuro-anatomy and clinical impact of lesions in different areas. Generally poor understanding of guidelines for stroke management.

Static Station: Difficulty in interpreting spinal imaging and analyzing the clinical scenario provided. Clinically relevant details missed or not interpreted correctly leading to less than optimal management choices.

Results of Examinations and Assessments 2012

Fellowship Examination Results

Written Examination

Number of candidates	40
Number successful	37
Pass rate	92%

Clinical Examinations

Number of candidates	41
Number successful	18
Pass rate	44%

Assessment Modules

Module 1

Number of candidates - March	22
Number successful	13
Number of candidates - September	21
Number successful	15
Pass rate	65%

Module 2

Number of candidates	40
Number successful	32
Pass rate	80%

Fellowship Written Examination - MCQ Paper

This year the pass rate for the MCQ paper was 95%.

Candidates when studying for their fellowship exams should be familiar with the AFRM curriculum. The questions in the multiple choice paper are designed to cover a breadth of knowledge from core Rehabilitation Medicine topics.

Leadership in Health Management – Queensland University of Technology 31/8/12 – 3/9/12

A group of four rehabilitation registrars attended one of the first accredited courses for the Health Administration and Management module, in lieu of the standard written module. This four-day course was held at the Kelvin Grove Campus at the QUT in Brisbane. Many more similar courses, each with a minimum duration of two days, have since been advertised.

We comprised Arooge, Jeyanthi and myself from NSW and Gayathri from Victoria.

We all arrived bleary eyed on Friday morning after catching (very) early flights from our respective states for an 8.30am start. There were about 40 attendees from various backgrounds including nursing and middle managers, physiotherapists, occupational therapists, pharmaceuticals and administration. We also met a delightful General Physician from Princess Alexandra Hospital in Brisbane who had a lot of insight into Rehabilitation Medicine. She and her colleagues regularly hold multidisciplinary case conferences and family conferences and start discharge planning from admission to hospital. She told us that her referrals to Rehabilitation are consultant to consultant and only once the specific rehabilitation issues and goals have been ascertained. We tried to convince her to move to NSW!

Back to the course...The catering was quite good and very frequent! The course convenor was organised, knowledgeable and adaptable (when speakers were late or unavailable, she quickly filled the gap and reorganised the day).

Day one focussed on clinical governance, in terms of safety and quality improvement. Public policy was discussed, and how it is used to solve problems and make positive change.

Day two started with a video of the Four Corners program about the neurosurgical outcomes at the Canberra Hospital. Then followed a discussion about healthcare adverse events in the last 20 years, including the Bristol Hospital Enquiry, the Harold Shipman case (UK), and more recently the events at Bundaberg Hospital, and how these have influenced current health policy and practice. The discussion reminded me of how changes in the procedure of death certification in the UK were heavily influenced by experiences from the case of Dr Harold Shipman. I recall the frequent reference to his name when House Officers (Interns) had to make regular calls to the local coroner for supporting certificates, and the follow-up phone calls from a more senior medical officer a few days after each death certificate was written, to confirm the circumstances of the death.

We then went on to discuss the various styles of leadership and participated in a fun workshop where groups were divided by personality type, and came up with their own set of beneficial attributes, motivators and stressors, and tips for others on how to best deal with them! Of course the “Owl” group were the most organised and considered in approach; we didn’t like chaos or disorder. The “Eagles” were cold and bossy, the “Peacocks” did lots of talking but weren’t very decisive, and the “Doves” were very passive and just wanted everyone to smile and say “Good Morning”! Note that this is a slightly biased and very over-simplified recollection of the types! Each group had plenty to offer as leaders with their various styles, all of which are helpful in different situations, and ideally we would all be understanding of each others’ style and take advantage of each of our strengths when appropriate. All of us could think of our colleagues who fitted into the various “bird” types in their leadership styles (what happens in Brisbane stays in Brisbane).

Saturday night was spent watching “Hope Springs” (extra-curricular activity) at the cinema, and it was definitely worth seeing. Meryl Streep performed excellently alongside Tommy Lee Jones to portray an older couple seeking rejuvenation of their relationship despite much resistance from the grumpy old husband! Very entertaining...3 ½ stars.

Day three started with a presentation about how to manage change within a healthcare setting, followed by a lively discussion on leadership, led by a comedic psychologist who had become an Associate Professor with the School of Management. Later we explored the impact of various forms of communication, including media relations on the public perception of healthcare. The day finished with a hospital board chair explaining the role of the board.

In the evening, much fun was had exploring Brisbane Town and riding on the Big Wheel (proving that it goes too slow to set off one’s vertigo!)

Day four started with a discussion on negotiation. Did you know that Kenya has the highest per capita mobile phone use, as they do not have land cable infrastructure? By doing a self-assessment we found out how good a negotiator we were. Then the CEO of the Mater Hospital in Brisbane discussed the values and organisational culture of his organisation and the impact of leadership and professional relationships on healthcare and outcomes, as well as different outcome measures.

Overall we gained a much better understanding about what goes on “behind the scenes” in healthcare, although we left a little bewildered as to the very small piece of the puzzle the “front-line” seems to make up. This may reflect the nature and emphasis of the course on high level management, however many aspects of healthcare management filter through to small units of management at a ward level. We enjoyed the interactive sessions in particular the personality and leadership styles session. We learned about quality and safety activities in different contexts and how they came to be in current practice. I personally felt that the course met most of our learning objectives for Administration and Leadership and was a good overview of this topic.

As far as the training curriculum, the only gap that this course left was not covering Learning Objective 1.3.4: design, implement and monitor health service delivery. Monitoring was covered, however perhaps some formal teaching on design and implementation of a service in our local or bi-national training could fill the gap.

Lucy Ramon
Rehabilitation Registrar, Sutherland Hospital

Clinical corner: medical restrictions to driving

Driving a motor vehicle is a complex task requiring intact perception, good judgement, responsiveness and reasonable physical capability (1). The list of medical conditions and treatment side effects that can impair driving is very long and many of the conditions are common. On detection of a medical condition that means the medical standards for driving cannot be satisfied, doctors should advise the patient not to drive (2). Doctors should inform patients of their legal obligation to inform the driver licensing authority (DLA) and their insurer of their condition, as well as advising them that driving during the period legally prevented by their medical condition will render them not only criminally liable, but also in breach of their third party insurance (3). Many patients are not aware of this (2, 5). The doctor should document the advice clearly in the medical notes (2), something we have been found not to do well (4).

The decision for fitness to drive is ultimately that of the driver licensing authority, and they may arrange further assessment of the patient as required (2). A conditional licence can be issued based on assessment by a medical practitioner, and it is safest to follow the Austroads guidelines, revised in March 2012 (6). Commercial driving criteria are stricter than criteria for driving private vehicles.

Although only South Australia has mandatory reporting, doctors should consider informing licensing authorities in cases where it is known that patients continue to drive against medical advice (3). Unfortunately, patients may choose not to report their condition and may not inform their doctor of relevant historical details. One study of patients advised by specialists to report found that only 27% did so.

Recently I looked after a 90 year old lady with zoster ophthalmicus and zoster neuritis, who also suffered unstable angina and a large NSTEMI during her admission. She had a background of stroke with residual right upper quadrantanopia, but was fully independent and driving. She wished to return to driving. What would you advise?

(1) Driving and your health, Austroads, NTC, Australia 2012

(2) Medical restrictions to driving: the awareness of patients and doctors Rosemary Kelly, Timothy Warke, Ian Steele, *Postgrad Med J* 1999;75:537–539

(3) Usefulness of Austroads' fitness-to-drive guidelines: lessons from the Gillett case, *Med J Aust* 2009; 190 (9): 503-505

(4) Driving assessment and rehabilitation after stroke, *Med J Aust* 2007;187(10):599, Zoe Allen, Julie Halbert, Lydia Huang

(5) Driving to distraction — certification of fitness to drive with epilepsy. Ernest R Somerville, Andrew B Black and John W Dunne, *Med J Aust* 2010; 192: 342–344

(6) Austroads Guidelines for Assessing Fitness to Drive, 2012 National Transport Commission

Mohammed Abdul Vaseem

Trainee Committee Report for Rhaïa

By the time this report is published, it will be almost the end of 2012. I hope everyone has had an enjoyable and productive year.

The Trainee Committee continues to meet regularly and its members represent your interests on various Faculty and College committees. Please don't hesitate to speak up if you have any suggestions or concerns.

We are continuing to plan the inaugural Annual Training Meeting for Rehabilitation Medicine Trainees, in Melbourne, which is confirmed for Sunday 3rd March, 2013. We are receiving excellent support from the Faculty and hope to present a fantastic program. We are also excited at the opportunity for trainees from various branches to meet and network. Please see the brochure in this issue of Rhaïa for further details.

By now, I imagine some of you have participated in management courses to fulfil the requirements of Module 5 (Admin). I would love to hear your feedback on this new pathway for completing the module – please let your branch rep or myself know your thoughts.

To those of you about to enter the world beyond training, as new Fellows: congratulations and good luck! All your hard work has paid off. For those of us continuing on in training: all the very best for the coming term, and I hope to see you all in Melbourne in March.

Kirrily Holton
Chair

FEC Chair's Report

The Chair and Members of your Faculty Education Committee have had a very busy time in the last few months, as the main cycle of education and training activities draws to a close for 2012.

The FEC met at the end of October, to review, recommend and complete the activities I report on below.

The College's Education Committee has approved the PREP handbooks for 2013, and is calling for expressions of interest for colleagues to join a working group to develop policies to support Trainees in Difficulty, especially in Advanced Training programs (which is the case with our AFRM program). Dr Jennifer Mann has stepped forward for this task. Staff in the College are preparing the next round draft documents for ongoing AMC accreditation of RACP education programs. Initial trial workshops for the new Supervisor Professional Development Program (SPDP) were conducted (including at the AFRM ASM) in 2012, and the evaluations were very positive, and a further workshop on a new topic is being prepared for workshopping in early December 2012, and roll-out in 2013 – come to the next ASM to sample it!

Coming now to Faculty matters, supervisor training in Long Case Assessment has continued in 2012, with a further videocast workshop linking Sydney, Brisbane and Melbourne in mid September, and a workshop held in Perth in late October. Dr Dianne Pacey and her working group will assume responsibility for the ongoing training of this particular supervisory skill in 2013.

Colleagues will know that a further round of new STP grants is planned in 2013, and FEC affirmed that the same vetting and approval process will apply to AFRM applications for positions in designated sites, as in previous years. The College has decided on a slightly different process, as their trainees do not rotate into multiple training sites, in the same way as most AFRM trainees do. Members of the FEC supported with gratitude a proposal from the NZ Branch to establish a trainee award in memory of Dr Chee Dick (Boris) Mak, and referred this proposal for discussion at the next Faculty Council meeting.

Colleagues will be aware of the small but steady stream of applications from International Medical Graduates (IMGs) who apply for specialist recognition and registration in Australia, and whose applications are handled through the College's Overseas Trained Practitioner (OTP) Unit. In part because of an increasing number of appeals in regard to process outcomes, in the overall context of the College's Governance Review, the College OTP Unit is considering centralising this process, but your FEC does not agree with this recommendation, as our training program is significantly different from other FRACP Adult Medicine programs, not least in our assessment requirements, and this matter was discussed at the recent November College Education Committee.

Proposals were discussed and endorsed, for AFRM Annual Scientific Meetings in Sydney in mid-September 2013 and jointly with the ANZSGM in 2014, it being almost ten years since our last joint meeting with the ANZSGM in Fremantle in 2004.

CPD continues as merrily as ever, and Fellows are reminded to enter details of their 2012 activities well before the March 31st 2013 cut-off date (see Ruth Marshall's report).

The Faculty currently has 190 trainees registered of which 13 are Paediatric Rehabilitation trainees. New procedures have been introduced for IRTs, which align better with College-wide models, and these should result in a more rapid turn-around, benefiting trainees and supervisors alike.

The accreditation of facilities for AFRM training continues, with updates to the front-end paperwork being noted. A Virtual Site Visit Survey training workshop is planned for 2013, and Dr Monika Ling was endorsed as a new VSV Surveyor of the AFRM.

Details of formal assessments conducted in 2012 were reviewed by the FEC, in preparation for the AFRM Assessments Workshop which took place in Sydney on Saturday 1st December 2012. Some adjustments to formal assessment processes in 2013 may be made as a result of this workshop, and all trainees and supervisors will be advised of any such changes at the start of the year.

In planning major assessments in 2013, a full-day marking workshop will be convened immediately following the FWE in May 2013, which it is hoped will considerably speed the process of making results available to candidates. While the paediatric FCE is planned to be held on the usual date in August 2013, the adult AFRM FCE will now be held in Sydney on Friday 9th August 2013, instead of on a Saturday, as in previous years.

The FEC is still discussing the practicality of holding the 2013 Module 2 assessment in two capital city sites simultaneously, with the new assessment site being in Brisbane. Things are looking good – watch this space.

Several trainees are on the cusp of completing their final external modules (hint, hint), and should break through into the sunny uplands of Fellowship in the coming weeks.

Andrew Cole
Chair, FEC

Reflecting on 6 years wearing the 'hat' as your Lead for Continuing Professional Development.

It is hard to believe that I started in this role in February 2007 – the six years have passed really quickly. During that time I have written four articles for Rhaïa each year (a feat in itself) and have chaired at least two teleconferences and two face-to-face meetings of the CPD committee (more recently called the CPD sub-committee of the Faculty Educational Committee) each year, have attended multiple teleconferences and face-to-face meetings of the RACP CPD committee and, more recently, the smaller (and dare I say more effective) RACP Expert Advisory Group on CPD, for which I am Deputy Chair and for a short period, acting Chair, have chaired the RACP My Resources Gateway working group and been a member of the RACP MyCPD Review working group. I was involved in the roll out of our on-line AFRM MyCPD process and provided the 'voice over' for the introduction to a 'how to do it' for the RACP MyCPD.

Prior to becoming the Chair of the Faculty CPD committee, I had become involved in a year long trial looking at improving my personal PD by developing a personal learning plan and then tracking the result. As a result I became very interested in what it really means to be involved in personal continuous professional development and how we could ensure that Rehabilitation physicians are at the forefront of this process and agreed to become the Chair of the committee.

Over the past six years, I have learnt to reflect even more on my own learning needs and have, I suspect, become increasingly critical, of passive learning situations (the sort that see me falling asleep in a lecture theatre) compared to active learning situations

where I am engaged in discussion, asking myself questions, actively seeking information and making changes to my practice as a result. As doctors an awareness of our learning styles and needs and the development of our own personal learning plans, coupled with a degree of critical thinking or questioning about what it is we need to know, need to learn and want to achieve, etc is important if we are to achieve continuing excellence in our practices.

Early next year, I hope a new CPD Lead will be appointed to take my place so that I can retire to the exalted position of 'immediate past chair' which means I will still remain on the committee for some time to come... and stop having to write articles for Rhaïa which I suspect very few people read.

Whether you are taking a break from work or not, now is the time to reflect on the year that was. Did you have a PLP? Did you achieve your CPD learning goals for 2012? Have you written up your 2012 Activity register yet? Have you gone on line to upload your points? What changes will you make to your CPD practices in 2013? How about reviewing your learning needs and setting some achievable CPD goals including setting time aside for personal 'active' learning AND setting time aside to look after yourself as well. Me? I'm going to write a PLP and will check and reflect on it each month to help in achieving my learning goals. As well I hope to walk with my dog more often and, just maybe, enjoy some 'free' time.

I wish you all a happy, healthy and safe Festive and holiday season and best wishes for 2013.

Signing off as your CPD Lead.

Ruth Marshall

The National Disability Insurance Scheme (NDIS)

The COAG meeting in July 2012 saw the support for the creation of an NDIS turn into a political reality. Following the release of the Productivity Commission's report in August 2011, it became clear that national reform of funding processes and services to assist Australians with disabilities and their families was going to be required. The Commission found that gaps in services were profound and systems to obtain support were both complex and inflexible. They responded to provide crisis intervention, rather than providing structured assistance and effective early intervention.

The idea behind a National Disability Insurance Scheme, which has bipartisan support, is to coordinate services across the states and territories to provide a system that recognises the needs of individuals and families. There is an NDIS Advisory Group chaired by Bruce Bonyhady which has been instrumental in the planning of the NDIS so far.

The NDIS has five launch sites: in the Barwon area of Victoria, South Australia, Tasmania, the ACT (for customers up to 65 years of age) and in the Hunter Valley in NSW, set to start operating in July 2013. The aim is to use these test sites to refine the organisational aspects and broader delivery of the NDIS with significant feedback from consumers. The NDIS Launch Transition Agency under the stewardship of CEO David Bowen is to be established as an independent body to assist in this process. The Agency will be established by legislation as an independent body under the Commonwealth Authorities and Corporations Act, as recommended by the Productivity Commission. Accountability to government will however be monitored by a Ministerial Council which will have representatives from all states and territories. The NDIS Launch Transition Agency will be overseen by a Board.

Invitations for submissions to assist in providing the framework have commenced and I am aware that the RACP and the AMA have provided constructive comment and information to the Minister for Disability Reform, Jenny Macklin, regarding issues of 'Reasonable and Necessary Support and Eligibility'. Not only is this input to plan the services but also to assist in the drafting of legislation regarding the NDIS and National Injuries insurance Scheme (NIIS) which is also underway.

There is a website "Your Say" which enables individuals and groups to contribute to feedback regarding the scheme. In a speech given on 31st October in Canberra, Jenny Macklin said that for the third tier of people needing higher level support, there will be flexibility in how people access funding and services throughout their lifetime. Minister Macklin mentioned that as a result of the feedback received, early intervention will be included in the scope of the draft legislation as well as mental illness and episodic disabilities. Reading this speech I am encouraged the RACP's letter has been both read and tabled. The aim is to endeavour to pass the legislation in a Bill prior to the end of the final sitting of parliament this year.

The major issue is to ensure clear guidelines for inclusion in the NIIS and NDIS so that gaming for schemes and services is prevented. The major difference between the two schemes is that the NIIS will provide for health services in addition to those related to disability. The NIIS will be funded from indemnity premiums and thus has different implications for physicians, however, where inclusion criteria are clear, medical negligence claims should in fact decrease.

Regrettably none of the areas included as launch sites are particularly rural or remote so that many unique difficulties already faced by people in these areas will not have the full benefit of trouble shooting during this transition phase. Another limitation is that not all age groups are represented at all sites. Concerns have been raised by people in better funded areas that existing services they enjoy may be placed in jeopardy as new competing services are funded. Sustainability and accountability of new services will require close observation.

The NDIS is becoming a reality and has much to offer the community. Feedback from clinicians will be extremely valuable in the framework and implementation stages and we will certainly feel its effects and hopefully its manifold benefits once it is introduced.

Katherine Langdon

AFRM Award Availability

Category	Name of Award	Amount
Research Entry	Arnott Research Entry Scholarship in Cancer Research	$ 30,000.00
	Basser Research Entry Scholarship	$ 30,000.00
	VFFF RACP Research Entry Scholarship in Rural Health	$ 30,000.00
	RACP Fellows Contribution Research Entry Scholarship (x2)	$ 30,000.00
	Shields Research Scholarships	$ 30,000.00
Post Higher Degree	Barbara Cameron/ARA Fellowship	$ 50,000.00
	Cottrell Fellowship	$ 60,000.00
	Diabetes Australia Fellowship	$ 50,000.00
	Vincent Fairfax Family Foundation Research Scholarship	$ 60,000.00
	RACP Fellows Contribution Fellowship	$ 150,000.00
	RACP Conrod Fellowship	$ 40,000.00
	The Sir Roy McCaughey Fellowship	$ 75,000.00
	The Servier Staff Research Fellowship	$ 10,000.00
Travelling	CSL Travelling Fellowship	$ 15,000.00
	IMS Overseas Travelling Fellowship	$ 15,000.00
Open	Kincaid-Smith Research Fellowship	$ 20,000.00
	Joseph Thornton Tweddle Research Scholarship	$ 3,000.00
Study Grants	Gaston Bauer Work Shadow Grant	$ 2,500.00
	Maynard Rennie Fellowship for Isolated Rural Physicians	$ 5,000.00
Indigenous	ATSI	$ 5,000.00
AFRM	RACP AFRM Research Development Scholarship	$ 30,000.00
	AFRM Bruce Ford Travelling Scholarship	N/A
	RACP AFRM Rural and Remote Scholarship	$ 2,000.00
	RACP AFRM ATSI & MT Scholarship	$ 10,000.00
New Zealand	RACP Fellows Contribution Research Entry Scholarship NZ	$ 30,000.00
	RACP Neil Hamilton Fairly Medal	Travel

How to Apply
Application forms can be downloaded from the RACP Foundation website: http://www.racp.edu.au/page/foundation. Applications must be submitted in a single document, pdf format, to Foundation@racp.edu.au by 5.00 p.m. AEST of the closing date.

Terms and Conditions
Terms and Conditions can be found at the back of the awards book and on the website. Please ensure you read them carefully.

Enquiries
Executive Officer RACP Foundation
Foundation@racp.edu.au or (02) 9256 9639

Is the NDIS the solution?....

In 20 years I want to be able to lean back in my recliner rocker and reflect on how the National Disability Insurance Scheme was one of the most significant Government reforms in recent times. It certainly has that potential. A universal consumer controlled funding scheme that will provide for all the needs of people with disabilities. How often have we as rehabilitation physicians dreamed of that? But does it provide all the needs?

The NDIS grew out of the National Disability Strategy which was signed off by Federal and State government leaders in February 2011. This strategy identified six key areas in our society that needed to be addressed to improve all aspects of the lives of people with disabilities. These are: 1) Inclusive and accessible communities; 2) rights protection, justice and legislation; 3) economic security; 4) personal and community support; 5) learning and skills; 6) health and well being.

The NDIS grew out of the fourth point, 'personal and community support'. It is aimed at providing care and support services and is one plank (albeit a mighty big plank) in the raft of ways to improve the lives of people with disabilities in Australia. So it's PART of the solution but not THE complete solution.

As rehabilitation physicians we are aware of the complex interactions between disabled people, their carers and support services, housing, transport, health etc. All interact in managing individuals with disabilities. Without all these planks in place, the NDIS may not work. But each plank is being looked at very separately and not as a part of the larger whole. So what does that mean? For one thing, all the different components of the disability strategy are based in different departments... we clinicians tend to be based in Health services, the NDIS is based in Family, Housing and Community Services (FaHCSIA). So it's no real surprise that the expert groups established to implement the NDIS consist of people from the community services sector and there are no clinician voices at all on these groups. Of course clinicians are not the key people in the NDIS, but to ignore us altogether in putting the scheme together is fraught with danger.

Further, as the NDIS is seen in isolation from other aspects of disability related issues, we have the situation where at the same time as the Federal government is committing to spending billions of dollars on the NDIS via FaHCSIA, they won't commit to any money past June 2013 for the subacute rehabilitation program (aimed at treating the effects of disability) currently being funded through the 'COAG' health money. Go figure.

The concept of the NDIS is a huge step in improving the lives of people with disabilities but it is not the only step. To cross this river, we need all six planks of the bridge in place.

From my recliner rocker in 20 years time I want to be able to say that the NDIS was a great reform – not that it *could* have been a great reform.

Jennifer Mann

National Partnership Agreement on Commonwealth Funding of Sub-Acute Services

In July 2008 the Council of Australian Governments (COAG) entered into a five year National Partnership Agreement (NPA) whereby the Commonwealth provided approximately $500 million in funding for sub-acute service to the States. This Agreement will end on 30th June 2013. No further funding has been included in the forward estimates. This places programs and positions at risk. AFRM President, A/Prof Chris Polous, and NSW Fellow, A/Prof Steven Faux, recently met with the First Assistant Secretary of the Acute Care Branch of the Commonwealth Department of Health and Ageing to outline the success of projects funded under the NPA. A review is soon to commence but the outcome is unclear. It will be important for Fellows to work through their Local Health/Hospital Districts, and their state health departments to highlight the benefits of the programs funded under the NPA – not only in terms of rehabilitation patient outcomes, but also in terms of system-wide improvements. The Faculty will do what we can to maintain this matter on the agenda, but each State Branch also needs to consider organising meetings with their local health departments. The table below provides a compilation of the work funded under the NPA from across the country.

LOCATION OF THE PROJECT	NATURE OF THE PROJECT	CONTACT
NEW SOUTH WALES		
Calvary Health Care Sydney	EXPNDED services: Therapy intensity, Geriatric Evaluation and Management	Dr Martin Kennedy/ Dr Karen Edwards
Camden and Campbelltown Hospitals	NEW Registrar position and Staff Specialist (geriatrician) position. Funds also included TESL, on-costs, goods and services plus RMR Medical staff duties include acute inpatient care, clinics, home visits, ACAT	Dr Martin Low
Children's Hospital at Westmead	IMPROVED ACCESS: Cerebral Palsy Assessment and Management Service including Spasticity and Movement disorder Management (Botulinum Toxin, Intrathecal Baclofem, Selective Dorsal Rhisotomy and Deep Brain Stimulation interventions)	Dr Stephen O'Flaherty
Hunter New England Local Health District	NEW service: multidisciplinary community rehabilitation to clients with polytrauma following discharge from hospital. The purpose is to minimise waiting time and risk of complications for trauma patients discharged from hospital, who require ongoing rehabilitation and are waiting take up of more formal/established outpatient/community rehabilitation programs. NEW service: Tele-Health Program. Purpose is to primarily support rural based clinicians and patients requiring rehabilitation inputs. EXPANDED service: 8 Subacute Beds at Kurri Kurri Hospital. Current focus is orthogeriatrics. Ultimately it will have 14 beds. NEW service: 16 Subacute Beds at Belmont Hospital. The purpose is to receive patients awaiting discharge from acute care with an anticipated length of stay of less than 10 days. NEW position: Geriatrician/Rehabilitation Physician in Tamworth (under the umbrella of 'GEM' Services). Not filled. EXPANDED: Paediatric Rehabilitation Services (under the umbrella of the John Hunter Children's Hospital). EXPANDED: Palliative Care Services	Dr Michael Pollack/ Dr Stuart Tan
Nepean Hospital	NEW service: Mobile Rehabilitation Team (MRT) providing in-reach into acute. Offers early rehabilitation to acute care patients.	Dr Sharon Wong
Mt Druitt Hospital	NEW service: Community Based Multi-Disciplinary Service developed for people of working age who have acquired disabilities following a stroke (SOS program). The patient centred practice focusing on goal attainment to maximise recovery.	Dr Alice Lance
Shoalhaven	NEW service: Acute Rehab team In-Reach into Acute. This initiative has had a significant impact on both acute and rehabiliation flow and length of stay. Excellent patient outcomes. This is the project that has been most beneficial to our service and hospital. There would be a significant impact on patient flow if we lost this service.	Dr Jeremy Christley
St Vincent's Hospital, Sydney	EXPANDED services to inpatients: We have employed (i) a technical aid. EXPANDED services to outpatients: We have employed 0.5 speech pathologist 0.3 occupational therapist and 0.3 physiotherapist. NEW: (i) Inpatient Mobile Rehabilitation Team (MRT) modelled after METS; (ii) Outpatient rehabilitation in the home team shared with Prince of Wales.	A/Prof Steven Faux
Sutherland Hospital	EXPANDED service: Increased therapy – increase in admissions and discharges; reductions in lengths of stay; aged patients able to be sent home; massive reduction in acute length of stay (reducing bed block); no capital costs	Dr Philip Conroy
Sydney Children's Hospital Randwick	NEW Community support: (i) transition to home in Southern and Illawarra areas for long stay patients; (2) outreach clinics to Illawarra; (3) group interventions for patient groups; and (4) education to local community services on paediatric rehab and brain injury rehab	Dr Adrienne Epps

LOCATION OF THE PROJECT	NATURE OF THE PROJECT	CONTACT
Westmead Hospital	NEW: Surgical Medical Acute Rehabilitation Treatment Project (SMART). 8 beds in the surgery unit (not additional but shared)	A/Prof Ben Marossezky
NORTHERN TERRITORY		
Royal Darwin Hospital	EXPAND service: Increase Bed Numbers at RDH. From 8 to 18 and create 12 restorative beds, leading to reduced waiting times and length of stay.	Dr Gavin Chin
QUEENSLAND		
Boonah Hospital	NEW service: Satellite Inpatient Rehabilitation Service for low intensity rehabilitation patients	Dr David Douglas
Carrara Rehabilitation Unit	NEW services: Carrara Inpatient Sub-Acute Beds, Memory Clinic and Falls, and Balance Clinic	Dr Ben Chen
Division of Rehabilitation, Princess Alexandra Hospital, Brisbane	INCREASE ACCESS: (i) Spinal Outreach Team; (2) Spinal Cord Injuries Unit and Brain Injury Rehabilitation Services. Spinal Outreach Team (SPOT) ~ $ 1.52 m over 4 years. Increase in general SPOT outreach and community services. Brain Injury Rehabilitation Inpatient Unit and Day Hospital ~ $2.34 m over 4 years. There are 4 initiatives: (i) expand brain injury inpatient and day hospital rehabilitation services; (ii) increase activity and services for people with acquired brain injury; (iii) Increase allied health services in the inpatient and day hospital setting; and (iv) provide social work and neuropsychology services in BIRU Day Hospital Spinal Injuries Unit ~ $ 1.42 m over 4 years. There are 3 initiatives: (i) Increase services and activity for people undergoing acute care and primary rehabilitation in Spinal Injuries Unit; (ii) Increase quality of care provided in the SIU by instituting a new Model of Care; and (iii) To provide a small staffing enhancement in the SIU to allow successful implementation of the first phase of the new SIU Model of Care including enhancement of existing allied health and nursing positions and establishment of several positions that have not previously been part of the SIU team i.e. Leisure therapist and wheelchair technician	Dr Tim Geraghty
SOUTH AUSTRALIA		
Country Health SA Health Network (CHSAHN)	NEW services: Introduction of Rehabilitation Services to 4 Country Centres. The services provided include inpatient rehab, home-based and centre based day therapy and outpatient rehabilitation. (i) Whyalla and Mt Gambier –inpatient and ambulatory; (ii) Port Augusta and Port Lincoln – ambulatory; and (iii) Berri – ambulatory service in development. Ambulatory occasions of service have almost doubled from December 2011 (459) to August 2012 (830).	Dr Charitha Perera
Concussion Clinic, SA Brain Injury Rehabilitation Service SA (BIRS), Outpatient Clinics, Hampstead Rehabilitation Centre, Northfield	NEW services: Concussion Clinic (February 2012) - To provide rapid follow-up clinic and expert assessment for patients admitted to acute hospital or ED clinic following traumatic brain injury and rapidly discharged; recommended by SA Rehabilitation Clinical Network re statewide Brain Injury Rehabilitation Model of Care. Cognitive, behavioural, balance screening performed, educational input re recovery and return to work strategies . Early intervention limits longer term morbidity and chronicity.	Dr Miranda Jelbert/ Dr Ruth Marshall
Hampstead Rehab Centre Central Adelaide	EXPANDED services: Ambulatory Services – (i) Brain: Concussion and ambulatory clinics; (ii) Spinal: Outreach follow up team; provision of multi-disciplinary clinics to the country; additional outreach clinics are planned across metropolitan Adelaide	Dr Charitha Perera
Modbury Hospital, Adelaide	NEW services (18 July 2012): Multi-Disciplinary Rehabilitation in the Home based at Modbury GP Plus Super Clinic): 7 days nursing and 5 days allied health. EXPANDED services: 15 ambulatory beds due to expand to 20 beds; 8 Inpatient beds; Musculoskeletal Outpatient Clinic Staff: 4.6FTE – Allied Health; 1.7 FTE – Nursing; 2.0 FTE - Admin	Dr Charitha Perera
Rehabilitation Registrar Brain Injury & Spinal Cord Injury (BISCI Registrar) Hampstead Rehabilitation Centre, Northfield	NEW position (January 2012): Registrar to provide earlier inpatient triage assessment and rehab consultation; facilitate earlier transfer from acute to rehab sector; support 4 new outpatient clinics in both Spinal Cord and Brain Injury Services; shorten clinic waitlists; allow timely follow-up of recent discharges; prevent possible readmission; assist allied health assessment and support in ambulatory services.	Dr Miranda Jelbert and Dr Ruth Marshall

LOCATION OF THE PROJECT	NATURE OF THE PROJECT	CONTACT
SA Spinal Cord Injury Service, Spinal Outreach Rehabilitation Team (Ambulatory service), Hampstead Rehabilitation Centre, Northfield, SA 5085	NEW Services: Spinal Outreach Rehabilitation Team - To facilitate discharge from the South Australian Spinal Cord Injury Service (SASCIS) inpatient service by assisting people to return to living and participating in the community and to facilitate outreach follow-up services for clients of the SA Spinal Cord Injury Service living in outer-metropolitan Adelaide and country South Australia. The SORT program actually requires several more staff so is currently only able to provide limited services. The program was originally envisaged and ultimately it is hoped that, with increased staffing SORT will also provide inreach support to people with spinal cord injuries in acute hospitals prior to commencing their intensive inpatient rehabilitation and to patients who have been readmitted with late complications such as osteoporotic fractures or pressure ulcers. Currently SORT provides the following multidisciplinary support for SCI clients: (a) Social Work; (b) Physiotherapy (c) Occupational Therapy (d) Nursing. To support country outreach clinics from 2013.	Dr Miranda Jelbert And Dr Ruth Marshall
Southern Adelaide LHN	EXPANDED service: Ambulatory and Day Rehabilitation Services – (i) Provision of clinics for MS, Parkinsons; new Driving Clinic; (ii) seven day rehabilitation service at Repatriation; (iii) REACT (Rehab in the Acute Team) at Flinders. Multi-disciplinary in-reach team, providing shared care management for 8-10 beds at Flinders Medical Centre with early supported discharge (MRT)	Dr Charitha Perera
Women's & Children's Health Network	NEW services: Ambulatory Rehabilitation Service. Multidisciplinary team providing inpatient and outpatient services. It has grown from a relatively new service in 2011 to running at close to capacity. Collaboration with Adult Spinal Cord Injury Service.	Dr Charitha Perera
WESTERN AUSTRALIA	General expansion of Hospital In The Home, and Community Rehabilitation, and Community Physiotherapy Services; and Day Therapy	Dr Ian Wilson
Bentley Hospital	NEW services: 10 bed Stroke Rehabilitation Unit; Parkinson's Disease Outreach Program	Dr Ian Wilson
Osborne Park Hospital; Swan Kalamunda Hospital	EXPANDED services: Parkinson's Disease Outreach Program – multidisciplinary allied health team with medical governance supports patients on an outpatient basis in the eastern metropolitan region. Day Therapy services have expanded.	
Princess Margaret Hospital for Children, Perth	NEW services: 10 bed equivalent intensive rehabilitation day unit – now called Irehab program.	Dr Jane Valentine
Sir Charles Gardner Hospital	NEW services: 14 bed Evaluation and Management Unit; Amputee Specialist Rehabilitation Services	Dr Ian Wilson
WA State-wide Sub-acute Training & Development Centres (TRACS)	WA State-wide Sub-acute Training & Development Centres (TRACS) NEW services: TRACS is the first of its kind in the State. It makes training possible through vide0-conferencing; self-paced packages; e-learning; communities of practice meetings; funding and support of skill exchange programs; workshops and seminars	A/Pro Chris Beer/ Ms Gail Milner

Remembering Dr Graeme Penington

Dr Penington passed away on 12 June 2012.

Dr Penington was a Founding Fellow of AFRM in 1993 and was the co-author of the book 'Introduction to Medical Rehabilitation, An Australian Perspective'.
Dr Sally Warmington was able to provide some insights into Dr Penington's life having worked with him.

During the 1980s and 1990s Graeme Penington was instrumental in the development of our young specialty. His influence was particularly important because he was working in geographical areas of Melbourne where our colleagues in other specialties, such as Aged Care, then had limited contact with Rehabilitation Physicians. Grae¬me was the Director of Rehabilitation at Mount Royal Hospital in Parkville (now Royal Park Campus of the Royal Melbourne Hospital) and for many years he was the sole Rehabilitation Physician in that organisation.

Although it took time and persistence, Graeme's work helped others to appreciate the unique contribution of Rehabilitation Medicine in a number of areas. After a study tour of the USA, Graeme worked with Speech Pathology colleagues to establish videoflouroscopy as an integral part of assessment for rehabilitation patients with swallowing disorders of neurological origin. He also worked with surgical colleagues to ensure that gastrostomy feeding became more widely available for patients with severe and persistent swallowing disorders after a neurological insult.

The amputee rehabilitation service at Mount Royal also developed and flourished under his directorship. This resulted in the integration of prosthetists into the rehabilitation team, the use of interim prosthetics and the employment of a second Rehabilitation Physician with a special interest in this field. This service went on to develop the successful multi-disciplinary course in Prosthetics and Amputee Rehabilitation, which has been run annually since 1998.

Those who had the good fortune to know Graeme will remember him for his generosity, enthusiasm and persistent support and advocacy for patients, colleagues and the specialty of Rehabilitation Medicine.

Sally Warmington

IAC PHOTO COMPETITION

Each year the International Affairs Committee runs a photographic competition for Fellows and trainees. The winner is the best photograph taken in an overseas location wearing either the Faculty tie or scarf.

This year's winner was Jagdish Maharaj with his photograph in the Olympic Stadium (front page).

Honourable mentions go to Sridhar Atresh for his photograph at the Arc de Triomphe in Paris and Gaston Nguyen for his photograph taken in France on Bastille Day.

Branch Reports

South Australia

Training matters

We have continued with the monthly tutorial and BNTP video conference program of teaching. One out of the two candidates passed the recent fellowship clinical exam and one out of three passed the Module 1 exam. Work has commenced on the teaching program for 2013, and we will be assisting the learning strategies for Junior Registrars as they prepare for their Module 1 exam.

For the first time, registrar applications for 2013 positions were received "on-line" via the RACP application/matching program. The program worked well, with the technical support provided being helpful, prompt and pleasant and the overall process provided a transparent and streamlined process. We thank the branch training co-ordinator Dr Andrew Wilkinson for his excellent work in making this possible and our next challenge will be implementing a "state-wide" registrar appointment system within SA Health.

Statewide Rehabilitation Clinical Network, South Australia

The Network will be coordinating the inaugural South Australian Rehabilitation Research Forum, to be held on Friday 15 March 2013 at the Stamford Grand Hotel, Glenelg. The Forum theme is "Translation of Recent Insights Into Practice" and aims to inspire delegates by showcasing research advances and quality improvement.

The Complex and Progressive Neurological Workgroup finalised their Rehabilitation Model of Care earlier this year. Budget pressures have delayed its progress; however the Network will be working closely with SA Health regarding strategies to ensure the gaps in services are addressed.

In recent months there has been significant progress in the development of rehabilitation services in the Northern Adelaide Local Health Network. Rehabilitation in the Home multi-disciplinary team, based at the Modbury GP Plus Super Clinic, has commenced services, providing seven days nursing and five days allied health. A musculoskeletal outpatient clinic has also commenced at Modbury Hospital.

AFRM SA Branch annual scientific meeting

SA rehabilitation medicine annual scientific meeting is being held on 23 and 24 November. The guest speaker for the annual dinner is Dr Phillip Henschke who will talk on *" The good doctor": what patients want- a view from the Medical Board".*

The Saturday morning talks will be by Dr Lyn Lee on *'Promoting Health in Young People with Disabilities'* and Dr Steven Zadow on *"New Advanced Musculoskeletal Procedures"*. This will be followed by registrar presentations on their research or quality assurance activities and a prize will be awarded to the best registrar presentation.

Best wishes for 2013!

Charitha Perera
Chair
AFRM SA Branch

Calendar of Notified Conferences

(This calendar is not a comprehensive list of all conferences relating to Rehabilitation Medicine)

2013

4-7 Feb 2013	14th WorldCongress - ISPO - Hyderabad, India http://www.ispoint.org/
6-10 Mar 2013	11th International Conference on Alzheimers and Parkinsons Diseases - AD/PD - Florence, Italy www2.kenes.com/adpd/pages/home.aspx
8-10 Mar 2013	'Rebuilding, Connecting, Living' - Nelson, New Zealand http://www.rehabconference2013.com/
10-13 Mar 2013	Neuroplasticity and Cognitive Modifiability - Jerusalem, Israel www.brainconference.com
17-20 Mar 2013	33rd Australian Pain Society Meeting - Canberra, ACT http://www.dcconferences.com.au/aps2013/
7-10 Apr 2013	12th National Rural Health Conference 2013 - Adelaide, South Australia conference@ruralhealth.org.au
17-20 Apr 2013	European Congress on OP and OA - IOF - Rome, Italy www.ecceo13-iof.org/
26-29 May 2013	RACP Congress - Perth http://www.racpcongress2013.com.au/
30-31 May 2013	Diabetic Foot Conference - Liverpool Hospital, Sydney http://www.endocrinesociety.org.au/Diabetic_Foot_Program_2013.pdf
16-20 Jun 2013	7th World Congress - ISPRM - Beijing, China www.isprm2013.org
3-6 Sept 2013	12th Australian Palliative Care Conference - PCA - Canberra www.palliativecare.org.au
18-20 Sept 2013	21st AFRM ASM - Sydney, NSW http://www.racp.edu.au/index.cfm?objectid=FD2F54F2-994B-F580-267B2BC4FC753EAC
1-4 Oct 2013	World Parkinson Congress - WPC - Montreal, Canada www.worldpdcongress.org
3-5 Oct 2013	Health Professionals' Health Conference 2013 - Brisbane, Queensland http://www.hphc2013.com.au/index.php
27-31 Oct 2013	8th Interdis Congress on Low Back and Pelvic Pain - IWC - Dubai http://www.worldcongresslbp.com/

2014

2-5 Apr 2014	World Congress on OP, OA and M/skel Diseases - IOF and ESCEO Joint meeting Seville, Spain http://www.esceo.org/

2015

6-11 Jun 2015	8th World Congress - ISPRM - Berlin, Germany www.isprm2015.org

Private Practice Opportunity
Cairns Private Hospital, Nth QLD

Cairns Private Hospital is seeking a Rehabilitation Physician* interested in establishing their private practice in partnership with the hospital.

Our current team of Specialists look forward to welcoming a full-time private rehab physician to the community.

ABOUT US

The hospital's Rehab Unit consists of 10 beds including a gymnasium and currently offers the following programs:

- Orthopaedic;
- Medical reconditioning;
- Post-op surgical reconditioning;
- Stroke; and
- Amputee.

Cairns Private Hospital is a modern 123 bed licensed facility, fully supported with 24hr in-house medial officers.

Cairns Private caters for a full range of specialties including orthopaedics, cardiology, general surgery, general medicine, plastic surgery, ENT, urology, ophthalmology, gastroenterology, sleep and respiratory and obstetrics and gynaecology.

INTERESTED?
Please contact Mr Steve Rajcany, CEO,
Cairns Private Hospital on 0400 347 331
or email: rajcanys@ramsayhealth.com.au

*** Must have FAFRM**

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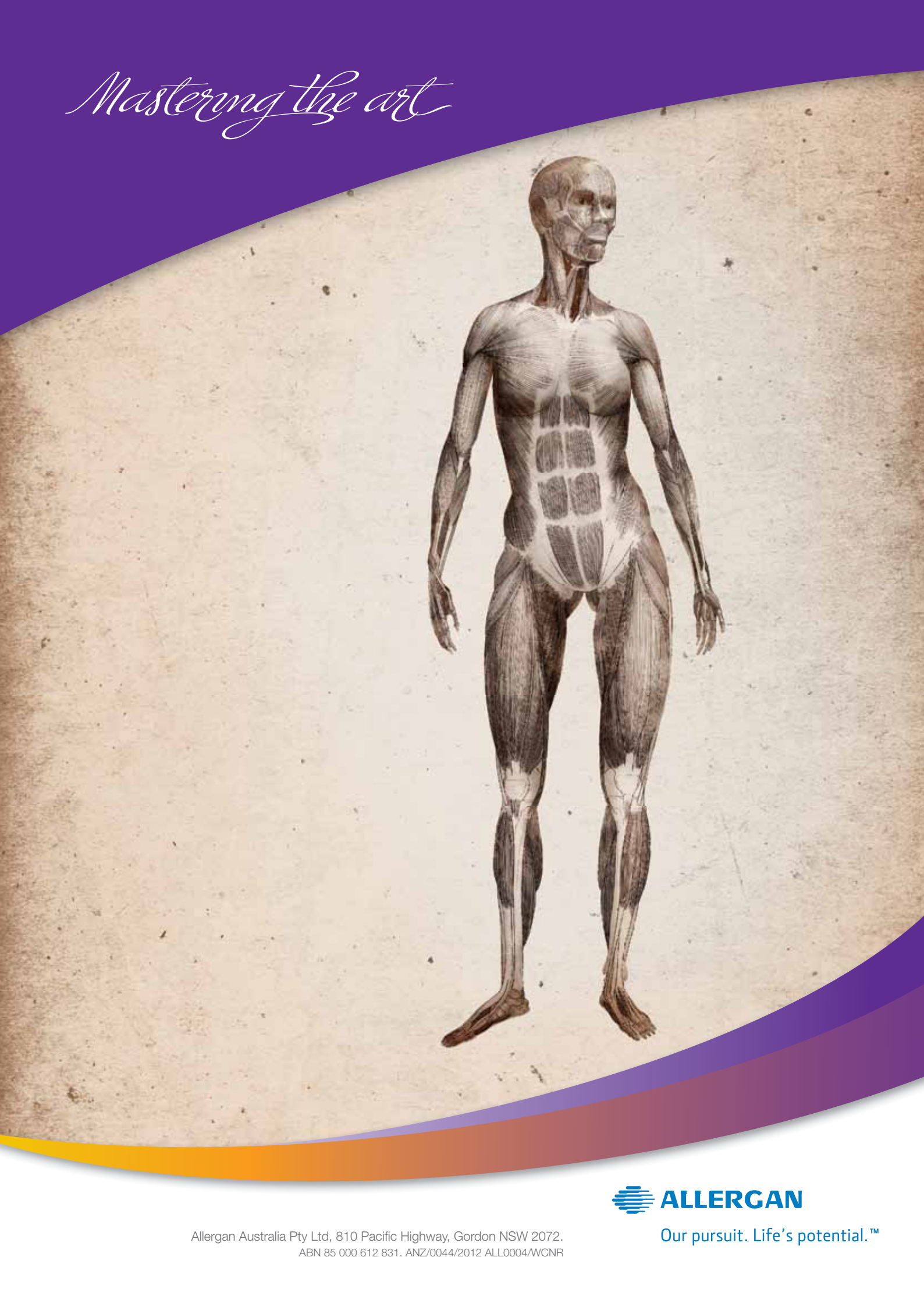

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