Celebrating a shared past, planning a shared future: physiotherapy in Australia and New Zealand

ABSTRACT

The purpose of this historiographical paper is to trace the links between New Zealand and Australia with particular reference to education and the author's engagement with these processes. From the educational beginnings of physiotherapy programmes in Melbourne (1906) and Dunedin (1913) following the formation of the Australasian Massage Association in 1906, the Association branches in New Zealand and Australia soon went their own way. Physiotherapy and its education programmes were strengthened in the poliomyelitis epidemics and the world wars. By the 1980s these programmes were closely integrated with tertiary colleges as well as the universities. The author was a participant in protracted political action by physiotherapists which resulted in a new programme at the University of Melbourne in 1991 and in the review of the programme in Dunedin in 1994. She facilitated educational ties across the Tasman and the formation of the Council of Physiotherapy Deans Australia and New Zealand. The paper supports the conclusion that many aspects of our shared history and growing relationships have been beneficial to education, accreditation and physiotherapy practice in both countries.

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Reaching the milestone of 50 years since graduating as a physiotherapist encouraged reflection on my personal history and that of the profession. Nicholls too recently encouraged New Zealand physiotherapists to collect professional history (Nicholls 2007). As the University of Otago celebrated the centenary of physiotherapy in New Zealand in 2013, I will focus on the universities with which I have had my strongest academic links - Melbourne and Otago. Their physiotherapy connections began over a century ago, when our forebears perceived an Australasian association would facilitate physiotherapy's development. Their original goals resonated with my own. This paper traces the formation of the Australasian Massage Association, the beginnings of physiotherapy education in Australia and New Zealand and our coming of age through poliomyelitis epidemics and the rehabilitation of the wounded of the world wars. My involvement with more recent educational challenges and their resolution followed by our increasing collegiality through the Council of Physiotherapy Deans Australia and New Zealand, which I instituted and my facilitation of our accreditation bodies will presage some ideas about a shared future.

We were joined together as part of Gondwana until some 100 million years ago.[1] Our indigenous people have been resident for long periods, Australians for 60,000 years and the Māori for 16 centuries. All through the 17th century European mariners sailed here; Abel Tasman named New Zealand and New Holland and James Cook claimed our countries for Britain's colonial expansion in 1769-1770. In 1788, the first settlers from England reached New South Wales (Grimshaw et al 2006). Medical men and non-medically qualified healers arrived with the early colonists and a century later the *Australasian Medical Directory and Handbook* of 1886 lists 257 practitioners in Australia without medical qualifications. A further 15 were practising in New Zealand. These practitioners included masseuses and masseurs, hydropathists and medical electricians (Martyr 2002, Pensabene 1980, Shaw 2013).

By the end of the century, medical practitioners were enjoying increased prestige with improved education and training, progress in science and less risky surgery (Coleborne and Godtschalk 2013, Pensabene 1980, Raftery 1999). Though much illness was managed within families, medical practice was gaining in respect and many physiotherapists were desirous of collegial relations with orthodox medicine. The *Australian Medical Journal* endorsed advertisements in 1879 and again in 1882 for professionally trained massage practitioners such as Miss Dick's gymnastic school as one: 'to which the profession may confidentially send such of their lady-patients as require the well-considered application of the sort of exercise that is necessary for the recovery of muscles' (1879, 1882). Miss Dick had undertaken the professional training and qualifications to be a teacher of gymnastic exercises. The term physiotherapy had been coined and by the end of the nineteenth century physiotherapy practitioners were using exercise, massage, electrotherapy and hydrotherapy (Korobov 2005).

THE AUSTRALASIAN ASSOCIATION

Unlike the beginnings of Britain's Chartered Society of Physiotherapy, which initially concentrated on massage and was driven by women nurses and midwives, male masseurs predominated amongst those promoting an Australasian association (Nicholls and Cheek 2006, Wicksteed 1948). Alfred Peters, son of a masseur, was born in Newcastle on Tyne in 1871, arriving in Australia in 1887. He established himself quickly as a well-patronised practitioner. He was an Honorary Masseur at the Melbourne, St. Vincent's and the Homeopathic Hospitals. He used the latest therapeutic devices treating notables such as Members of Parliament, famous sportsmen and Anna Pavlova (Liddicutt 1987, Peters 1987). Peters authored books on massage (Edwards 1916,

[1] We were not always separated by a sea but joined together as part of Gondwana until some 100 million years ago as exemplified by shared plants such as the *Nothofagus*, the beech tree. *Nothofagus* information at en.wikipedia.org/wiki/File:Nothofagus_range_including_New_Caledonia.jpg Accessed 8 March 2013.

Peters 1890, Peters 1892). He participated with Heinrich Best in a 1905 meeting convened by Teepoo Hall. Hall already contributed to the medical establishment, teaching medical students and may have been the group's connection to Dr John Springthorpe (Bentley and Dunstan 2006). Hall and others who trained physiotherapists, were concerned about the state of practice (Australasian Massage Association 1907). They were firm advocates for physiotherapy, which was recognised as an aid to physicians and necessary to effect the work of surgeons. Medical patronage legitimised the physiotherapists, adding to their status and facilitating access to the universities. Hall insisted that 'every patient should be examined by a legally qualified man as a fit subject for massage' (Anon 1896). Eliza McAuley, one of the women physiotherapists, pioneered studying anatomy at the University of Melbourne, teaching students and working at the Melbourne Hospital (Cosh 1987).

On 15th March 1906 the Association was formalised with Edwin Booth from Dunedin present (Australasian Massage Association 1906b). At the next month's meeting Mrs DE Booth, his physiotherapist wife joined (Australasian Massage Association 1906a). The Booths were well-established in Dunedin, favoured by eminent members of the community and treated artists such as Paul Cinquevalli, the Prussian juggler (Australasian Massage Association 1906e). Women like Miss Culling, were also practising (Otage Daily Times 1902)

The new Association, with John Springthorpe from Melbourne as the first president, made significant decisions regarding a uniform system of education and examination and proposals for registration. Teepoo Hall was the Australian secretary and Edwin Booth the New Zealand secretary (Otago Witness 1907). New Zealanders and Australians shared a common heritage, language and lifestyle; many relishing the prestige in being a part of Britain's empire. In the 1880s and early 1890s an Australasian inter-colonial convention preceded the British Parliament passing the Federal Council of Australasia Act 1885 (UK). Sir Henry Parkes spoke at the Tenterfield School of Arts on 24 October 1889 endorsing the federation and the Constitutional Conventions were convened, New Zealand proposing the Commonwealth of Australia in 1891. Initially New Zealanders strongly supported federation but became disillusioned by the reduced autonomy, the geographic distance of the new federal government and a disadvantageous voting system. The Australian Natives Association promoters of the federation hosted the second Constitutional Convention (1897-1898) supported by Sir Edmund Barton. After two referenda, 1898 and 1899, a majority of Australian colonies agreed. The Commonwealth of Australia Constitution Act 1900 (UK) took effect on 1 January 1901 (McQueen 1970). Despite no Australasian federation, links between the two countries remained strong and many Australasian associations developed and continue.

Connections between Australasian physiotherapists strengthened initially. At the first Association Annual General Meeting in Adelaide in 1907, 302 members attended: seven from New Zealand. Continuing education began with the first monthly lecture given by Dr Hugh Murray describing and demonstrating X-rays, including of the chest on a living subject (Australasian Massage Association 1906d, 1906e). Such lectures were printed *verbatim* in the *UNA Journal* provided to members.

> Massage … advanced towards recognition as a profession through skillful association with medical practitioners. By accepting a prescribed, subordinate and largely gendered relationship to orthodox medicine and its practitioners, massage escaped the stigma attendant on and hostility directed towards 'quackery' by the orthodox profession (Martyr 1997).

In Australia State groupings amalgamated within the Association but branches remained in New South Wales, South Australia and Victoria. By 1909, Wellington, Christchurch, Dunedin and Rotorua were organised into Association branches, although soon there were divisions between the centres analogous to that occurring between the Australian States. Peters had already resigned from its Council and continued teaching his own apprentices. In 1916 he established the Victorian Massage Association whose members did not require medical referral (Liddicutt 1987). Despite tensions and differences within the Association, the education principles established at the first meeting were enacted in Melbourne in 1906, Sydney 1907, Adelaide 1908 and in Dunedin in 1913.

THE BEGINNING OF PHYSIOTHERAPY EDUCATION

The Association's Council approved the two-year education programme of the diploma of 'Member of the Australasian Massage Association' (Australasian Massage Association 1906b). At the University of Melbourne, physiotherapy students shared components of their course with medicine (Russell 1977). The Professor of Anatomy, Richard Berry taught anatomy, Professor of Physiology, William Osborn was responsible for physiology. The medical electricity teacher was Dr Hugh Murray, an Edinburgh University medical graduate, holder of an extramural massage certificate from Edinburgh and thus a full Association member. Dr Colin Mackenzie lectured on the Theory and Practice of Massage. A physiotherapist, Lars Grundt, an exponent of Per Henrik Ling, taught medical gymnastics (Australasian Massage Association 1906c). The early students included women and men. Concurrently a modified course was repeatedly run for existing practitioners. Advertising reinforced the importance of qualifications and Association membership. John Springthorpe too promoted the Association at the medical congress in Dunedin in 1907 (Shaw 2013).

Although New Zealand had early physiotherapists like the Booths, and several hospitals taught massage techniques to nurses with Auckland Hospital offering a certificate, those desirous of completing physiotherapy education needed to travel to Australia or England (Shaw 2013). The Australasian links strengthened with Lily Armstrong. She trained in England, promoted the Australasian Association in New South Wales and taught at the University of Sydney from 1907; she gained further experience in England before travelling to New Zealand. Armstrong taught massage, medical gymnastics classes and treated patients in Dunedin Hospital when physiotherapy education began in 1913 at the University of Otago (Shaw 2013). Local medical men Professors John Malcolm and Louis Barnett and the Inspector-General of Hospitals, Dr Thomas

Valentine supported the two-year university and hospital programme based on the 1906 Australasian model. Dr Percy Cameron taught medical electricity, the Edinburgh-trained William Newlands anatomy and Professor Winifred Boys-Smith physiology. Although educational responsibility later transferred to the Otago Hospital Board, agreement continued with the University to teach anatomy and physiology (McMeeken et al 1995). Establishment of the educational programmes ensured that physiotherapists were on hand when poliomyelitis epidemics and world wars necessitated their expertise. The opportunity to contribute to rehabilitation provided a clinical space for physiotherapy to develop where medical practitioners had limited knowledge and fewer skills or time to devote to prolonged rehabilitative treatment.

ADVANCEMENT

Although poliomyelitis cases were reported from the late nineteenth century, Australia's first epidemic was in 1908 and New Zealand's in 1914, with nearly 1000 cases in 1916 (Ross 1993). Epidemics were a scourge in both countries for fifty years until vaccines reduced their incidence. Physiotherapy was the foremost treatment (Mackenzie 1918). The exchanges between countries was exemplified when in 1916 the New Zealand Department of Health brought the physiotherapist Florence Bevilaqua from Australia to train physiotherapists (Bentley and Dunstan 2006). Bevilaqua, who reportedly obtained extraordinarily good results, had been a Melbourne student (Ross 1993). Both countries benefitted from the pioneering work of Colin Mackenzie and physiotherapists, such as Bevilaqua, and particularly Vera Carter, who further developed muscle testing and re-education (Kelsall and McComas 1966). In Melbourne, in 1933 a third year was added to the physiotherapy programme to accommodate muscle testing and re-education.

New Zealand's 1916 epidemic reinforced the need for experienced physiotherapists. Practitioners already in England with the army were sent on courses on electrical treatment and Swedish remedial exercises. Australian physiotherapists had taken such courses during their training and were employing these treatments during their wartime and later practice (Butler 1943). It is difficult for those who did not experience the polio epidemics to understand the fear generated in communities. In Whangarei initially schools were closed when the nearest case was 200 miles away, later if ten miles distant. Eventually schools reopened, but theatres, kindergartens and pools remained closed (Ross 1993). My siblings and I were born following the largest epidemic in Victoria and my physiotherapist mother was treating polio patients whilst kindergarten teachers looked after us. The high levels of independence and autonomy experienced particularly by physiotherapists in the domiciliary polio service, I contend, were major factors in the professionalisation of physiotherapists.

Polio and wartimes were intertwined for physiotherapists. The intervening wars intensified the requirements for physiotherapy and cemented the concepts of rehabilitation and reconstruction (Adam-Smith 1984, Bentley and Dunstan 2006, Butler 1943, Ford 1996, Fussell 1996). World War 1 contributed a shared mythology about the ANZACS and to the development and recognition of physiotherapy. In Australia a public massage scheme raised funds for qualified physiotherapists (The Brisbane Courier 1915). Despite initial reluctance to include physiotherapists, the Medical Corps of both countries soon sought more practitioners from accelerated courses and specialist roles developed (The Sydney Morning Herald 1891, Pickstone 2000). Following their experience with soldiers' horrific injuries, surgeons gained confidence in rectifying problems in civilians. Orthopaedics and plastic surgery, both highly reliant on physiotherapists, expanded following the war (Beasley 2009, Bentley and Dunstan 2006, Butler 1943, Cooter 1993, Tidswell 2009, Wilson 1995).

By World War 2, the need for physiotherapy in acute care and rehabilitation was generally well-recognised and many Australasian practitioners contributed (Adam-Smith 1984, Shaw 2013, Wilson 1995). New Zealand's policy was to return wounded service personnel home and no overseas Corps was formed. The Australian Army Medical Corp's Chief Physiotherapist, Captain Alison McArthur Campbell taught remedial exercise to students from the 1920s, ran a private practice in conjunction with hospital work and was amongst the first women physiotherapists to enlist. She served in Egypt, Libya, Palestine and Australia. Other male and female physiotherapists served in the Pacific theatre and as in New Zealand in repatriation hospitals at home. Pay was a significant issue throughout the war with women earning about 60 per cent of men for identical work (McArthur Campbell 1978, Shaw 2013, Walker 1961, Wilson 1995). Physiotherapists undertook a wide variety of technically difficult work. This included preparation of plaster and application and removal of casts, restoration of function in many medical and surgical conditions, including in thoracic units, plastic surgery, orthopaedic wards, fitting boots, foot care, assessment, splinting and treatment of nerve injuries, long-term rehabilitation in convalescent depots and of seriously affected soldiers, including prisoners of war (Walker 1961). During this war increasing numbers of students required the Dunedin School to expand its clinical sites to Auckland, Wellington and Christchurch. Returning veterans were accepted as students in both countries expanding the demand on clinical placements and the numbers of male physiotherapists (Luke 2013, Luke 1987, Shaw 2013, Wright 1987).

British influence was stronger in Dunedin than in Melbourne, especially from the 1920s onwards when Britain's system of teacher training was adopted (Shaw 2013). A new modern building for the School of Physiotherapy opened in Dunedin in 1946. Although Victorian students also enjoyed university facilities, they languished as guests in hospital departments for physiotherapy teaching. All these graduates though were able to register.

Legislation for registration was first passed in Victoria in 1921 and recognised practitioners from Australia and New Zealand. In the latter country registration was achieved the same year. In New Zealand physiotherapists holding British certificates were able to register (Shaw 2013). The Victorian Act, however, allowed for reciprocity of registration with those trained and registered in the British Empire but not the unregistered British

physiotherapists. They could work in hospitals but not private practice (Liddicutt 1987).

The Acts in both countries vested responsibility for the educational programmes in the Registration Boards. Victoria delegated the educational responsibility to the leader of the programme, whilst in New Zealand the Board conducted a State examination (Cosh 2013).

DISJUNCTIONS AND REUNIONS

From positive early beginnings and with practice well-established, the Association's activities were generally State or regionally based and tensions remained in matters such as adoption of a standardised curriculum and admission to membership (Australasian Massage Association 1908, Shaw 2013). In Victoria tensions simmered with two organisations representing physiotherapists, the larger Australasian Physiotherapy Association comprising nearly all the practitioners in the public sector and the smaller Victorian Massage Association predominantly men in private practice. Once the medical referral ethic[2] was rescinded in 1976 the smaller association joined the larger (Peters 1987).

During the hard economic years after World War 1 and the depression, many Australian physiotherapists worked as volunteers in public hospitals and undertook private practice as their main source of income (Cannon 1983, Cannon 1996, Grimshaw et al 2006, Lowenstein 1978). Despite these difficulties congresses took place in Sydney in 1933 and Adelaide in 1936. The challenges and demands of practice and of geographic distance had reduced connections between Australia and New Zealand and discussion regarding New Zealand being effectively reincorporated into the still Australasian association bore no fruit. Subsequently in 1939 Australia replaced 'massage' with 'physiotherapy' and became the Australian Physiotherapy Association (Forster 1969). Nevertheless, educationally the Australasian Massage Association moved along relatively similar paths in Melbourne and Dunedin. As recognition and employment opportunities increased, shortages of physiotherapists continued in both countries. Regardless of heavy workloads, physiotherapists strengthened their professional activities. The New Zealand journal commenced in 1939 and the New Zealand Society of Physiotherapists was firmly established in 1950. The *Australian Journal of Physiotherapy* commenced in 1954.

The education of physiotherapists was at degree level by the 1970s and 1980s. Our physiotherapists were world-leaders particularly in manipulative physiotherapy. Our physiotherapists pioneered independence and autonomy in clinical decisions and patient access. The New Zealanders, Robin McKenzie, Stanley Paris and Australian Geoffrey Maitland are well-known, as is Prue Galley for her ground breaking paper on autonomy (Galley 1975). However few know that physiotherapists in the Victorian Health Department began the reconsideration of the medical referral ethic for membership of the Australian Physiotherapy Association. Elizabeth Fussell was Physiotherapist in Charge (1967-1986) of the itinerant polio service, which became available for people with other neurological conditions. Fussell introduced, in 1972, an independent consultancy for early childhood development assessment. Physiotherapists assessed and referred children to medical practitioners. Fussell realised that under these circumstances her physiotherapists could no longer ethically be members of the Association (Cosh 2013, Fussell 1996); thus setting in train the proposals which, after considerable debate, were recognised by the World Confederation for Physical Therapy (Bentley and Dunstan 2006).[3] In the next decade further significant changes to physiotherapy education occurred in Melbourne and Dunedin.

REVOLUTION

In the 1980s Australia experienced a major upheaval in tertiary education (O'Neill and Meek 1994). The Federal Government considered that higher education and Australia would benefit from fewer and larger tertiary institutions (Dawkins 1987a, Dawkins 1987b, Dawkins 1988). Government set minimum institutional sizes and used financial incentives to drive mergers with 19 universities and over 40 Colleges of Advanced Education amalgamated into a Unified National System comprising 35 universities (Harman 2002).

A proposed amalgamation between Lincoln Institute of Health Science and La Trobe University preceded the educational reforms. The Victorian School of Physiotherapy was based at Lincoln, although anatomy was still taught at the University of Melbourne. The merger proposal concerned physiotherapists (McMeeken 1987). Whilst physiotherapists were instrumental in forming Lincoln, they considered their influence had diminished; they were not consulted regarding the amalgamation and were at risk of submergence into a generic health profession (Australian Physiotherapy Association 1987). Despite physiotherapy's concerns both Federal and State governments supported the flagship amalgamation.

I was a member of the Australian Physiotherapy Association's Campaign Committee formed to oppose the amalgamation. The Association's *The Future Direction of Physiotherapy Education and Practice* guided intense political lobbying from 1987 to 1990 (Australasian Massage Association 1987). This included meetings with Vice Chancellors of all Victorian Universities and Federal and State politicians. Letters assailed politicians and media were targeted. Hundreds of physiotherapists and current students staged a march through the city of Melbourne

[2] In the reports of meetings of the new Australasian Massage Association in 1906 the requirement for treatment only to be undertaken on medical referral was frequently stated. In the report in the UNA nurse's journal of 30.5.1907 p35 at the first Annual General Meeting on 25.4.1907 it was stated "it was made a condition of membership that no member should act in a professional capacity, except under medical direction or supervision, and that no member should prescribe remedies for the cure of disease unless a registered medical practitioner".

[3] Australia debated this first ethical principle in the early 1970s and rescinded it from the Federal Constitution of the Australian Physiotherapy Association in 1976. Such a change had been debated elsewhere but Australia was the first country to formally make the change, three Australian members raised the matter of autonomous, primary contact practice at WCPT in 1978. Not all WCPT members agreed and I understand there was even talk of expulsion of Australia (Patricia Cosh Interview 25.2 2013). Finally the WCPT meeting accepted the Australian proposal that the issue of primary contact status be interpreted in each country according to their own standards.

culminating in speeches at Parliament House. After three years of meetings and intense lobbying, in July 1990, Federal and State Governments capitulated with a compromise solution to begin a new physiotherapy programme at the University of Melbourne. Following my initial secondment to the University to develop the curriculum, consult on the building and equipment and appoint staff, I was appointed as the Foundation Professor and Head commencing a new School of Physiotherapy at the University of Melbourne in 1991. In the early 1990s there were also difficulties regarding physiotherapy education in New Zealand where physiotherapists wanted to be responsible for their own body of knowledge; to have degree-based education and access to their own research and higher coursework degrees.

Across the Tasman Australian physiotherapy Schools were offering degrees (Chipchase et al 2006). With the New Zealand Physiotherapy Board entry-level practitioner competency document developed, in 1991, the four-year Bachelor of Physiotherapy commenced jointly within Otago Polytechnic and the University of Otago. This arrangement created problems of academic philosophy, communication, content and timetabling. Universities found physiotherapy students attractive with the high course demand and entry scores. The Faculty of Medicine at Melbourne then had the highest percentage of physiotherapists doing research higher degrees and the University of Otago had also commenced formal postgraduate programmes under the leadership of Dr Robyn Grote.

In Dunedin debate simmered regarding the conjoint undergraduate physiotherapy programme as physiotherapists watched the outcome of the Campaign in Melbourne. In 1994 Dr Graeme Fogelberg, Vice-Chancellor of the University of Otago commissioned Emeritus Professor Thomas O'Donnell as Chairman, Mr Michael Lamont and me, to review the arrangements for providing the Bachelor of Physiotherapy. We were to consider all aspects of the undergraduate course, the provisions and opportunities for research and for postgraduate academic and professional training. We were to make recommendations to the University concerning appropriate ways of addressing any issues and to consider their financial implications. Following wide consultation we recommended that the University of Otago become responsible for all physiotherapy programmes within a new University School of Physiotherapy. This school should review the curriculum and with the University plan staff development (McMeeken et al 1995). As in Victoria, many Dunedin physiotherapists considered they had returned to their *alma mater* where they had made many lifelong connections with their later medical colleagues and where they had studied the biomedical sciences, physiology, pathology and most particularly anatomy.

The study of human anatomy has had a long and turbulent history, but the politics of anatomy are equally intriguing. It was centre stage in arguing for Australasian physiotherapy education within the universities a century ago and a key focus of the political agenda for physiotherapy returning to the founding universities in the 1990s. As knowledge has increased, the attention paid to subjects in previous decades has changed; however, anatomy has remained central (McMeeken et al 2005, McMeeken 1998, McMeeken 2007, Nicholls et al 2009). Did the mystique of anatomy, its privileged knowledge, which we share, and the status associated with our medical links and their power some of the reasons for physiotherapists wanting recognition in the universities? Perhaps all of these are reasons, but the universities were courting physiotherapists too! With the formal reintroduction of physiotherapy into the universities, those of us on the academic and clinical staff were absorbed in developing and implementing new curricula and establishing strong Clinical Schools to integrate clinical education with the academic components of our programmes. With my opportunity to undertake a forensic review of the undergraduate and postgraduate physiotherapy programmes in Dunedin and the responsibility of introducing these programmes at Melbourne, I was struck by the similarity of our academic demands and the politics of education and health and considered there was much we could learn from one another and the more established schools.

RECONNECTING

In 1994 I proposed that the Heads of all the Schools of Physiotherapy in Australia and New Zealand meet twice yearly to develop educational and research alliances, for mutual support, to discuss the politics of the time, particularly as they related to education and health, and to act as appropriate in a collegial and collective fashion (Council of Physiotherapy Deans Australia and New Zealand 2013). As an example of the breadth of topics, those discussed at a 1994 meeting included community expectation of accountability and accreditation of physiotherapy academic programmes, discharge and readmission policies in hospitals and of critical immediacy the challenges of infection control when HIV/AIDS testing and activities by positively diagnosed students and staff were under debate. We agreed on advice for our prospective students. Other curriculum matters considered included cardiothoracic teaching, clinical education management, approaches to Honours programmes and student research projects. We explored strategies for offering postgraduate clinical specialisms, (thus initiating the first postgraduate coursework Masters) whilst ensuring adequate support for PhD candidates. We shared multimedia information and discussed the degree of independence for new graduates and an internship year. Physiotherapy competencies and their use in curricula and potential accreditation were debated. There was no enthusiasm for a common curriculum and we agreed that diversity sowed the seeds of innovation. We saw it as our role to liaise with external groups and to publically demonstrate accountability, leading to a comprehensive benchmarking study (Higgs and McMeeken 1997a, Higgs and McMeeken 1997b, Higgs and McMeeken 1997c). Evaluation of student outcomes from the perspective of the graduates and their employers was raised and later developed into survey tools used by our universities and subsequently required by accrediting authorities – the first in the health sciences to do so. As the number of Australian universities offering physiotherapy programmes grew from six in 1991 to 17 in 2013 additional new Heads joined the group (Council of Physiotherapy Deans Australia and New Zealand 2013). With few very experienced physiotherapy faculty members, the group has provided collegial support

and corporate knowledge. My intent was to ensure this group had a political profile for physiotherapy education. Now the Council of Physiotherapy Deans Australia and New Zealand continue to meet twice each year, maintain political advocacy for physiotherapy research and education and are mutually supportive. As the Head of a physiotherapy school, for an extended period, I represented all the Heads on the Australian Physiotherapy Council.

The Australian Physiotherapy Council has the responsibility for accreditation of Australian physiotherapy programmes. During my long involvement with the Council, since its responsibilities for programme accreditation began in 1996, my Council colleagues and I fostered further opportunities for collaboration with New Zealand. The trans Tasman Mutual Recognition Agreement of 1997 between our Governments has facilitated intercountry mobility of physiotherapists and from the mid 2000s our registering and accreditation authorities have formed sustained linkages with the purpose of sharing knowledge and expertise. Under the Agreement, physiotherapists with full registration and a current practising certificate of the Physiotherapy Board of New Zealand can apply for General Registration to the Physiotherapy Board of Australia but must apply to the Australian Physiotherapy Council for a skills assessment if they wish to migrate (Physiotherapy Board of Australia 2012, Bureau of Statistics 2009). The Intergovernmental Agreement, whilst strengthening working relationships between our organisations, has presented problems, particularly for New Zealand when international physiotherapists gain registration in New Zealand and then promptly translate across the Tasman avoiding Australia's more costly process and depriving New Zealand of much needed physiotherapists (Australian Council of Physiotherapy Regulating Authorities 2003, New Zealand Society of Physiotherapy 2008).

A SHARED FUTURE

Since the initial exchanges between Australia and New Zealand and particularly in the last two decades shared research, educational and professional activities have grown (Crosbie et al 2002). In 2007, Professors Mark Henaghan and Helen Nicholson, Messrs Martin Chadwick and Brett Woodley and I were pleased to undertake a review of the School of Physiotherapy at the University of Otago and note,

> Its continued evolution to an academic department with vibrant research, learning and teaching which attracts both local and international coursework and research students and furthermore for the local profession … for the generous way in which they work with the Physiotherapy School (Henaghan et al 2007).

There are many opportunities for future alliances with increased educational harmony, research collaboration, cooperation on accreditation and registration matters and joint political advocacy. The challenges and tyranny of distance faced a century ago have disappeared with ease of travel for face-to-face meetings and electronic communications.

I would encourage closer collaboration in further development of specialisation. The Australian Physiotherapy Association first proposed specialisation in 1954 and the Australian College of Physiotherapists was inaugurated in 1971. Roberta Shepherd and Barry Stillman were awarded the first Fellowships by original contribution in 1977, followed by Geoffrey Maitland, Jeanne-Marie Ganne and Janet Carr (Australian College of Physiotherapists 1969-1980). This occurred when postgraduate diplomas (1974) and physiotherapy undergraduate degrees (1977) commenced. Later fellowship by specialisation in orthopaedics (manipulative and sports), neurological, cardiothoracic, obstetrics and gynaecological and paediatrics were available, first awarded in manipulative physiotherapy in1984, to Patricia Trott, Brian Edwards and Geoffrey Maitland. The New Zealand Physiotherapy Society was similarly debating issues of professional development and a New Zealand College commenced in 1993 (New Zealand College of Physiotherapy 2013).

Uptake of specialisation was slow in Australia until recently when a new three-tier process was introduced, increasing numbers substantially (Australian College of Physiotherapists 2013). I contend that it is timely for shared specialist disciplinary colleges, as foreshadowed by the specialist Sports physiotherapy groups collaborating. The Royal Australasian College of Physicians is responsible for training, educating, and representing over 9,000 physicians and paediatricians in Australia and New Zealand. This is one example of many specialist Australasian health and medical discipline alliances. We set the scene in this part of the world with an Australasian association to represent our members. Is it timely to reconsider strengthening our ties further as we address the opportunities and challenges of this millennium?

KEY POINTS

- Australian and New Zealand physiotherapists agreed on their educational and professional requirements in 1906.
- Since the 1990s the association between the two countries has been strengthened through political action, the Council of Physiotherapy Deans Australia and New Zealand, accreditation and registration processes.
- Further collaboration such as in specialisation is encouraged.

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CONFLICT OF INTEREST

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