PART A: The clinician’s perspective: The confusion caused by conflicting evidence
by Tasha Carmichael, BScPT

Keeping up with research is important to me. It seems like there’s a never ending list of articles I want to read and new and exciting research coming out every day. It’s challenging to keep up with it all.

On the other hand, I often find the literature confusing. I don’t understand the statistics or the detailed analyses, nor do I aspire to understand them better. I’m nerdy, just not that nerdy and I’m really only interested in the bottom line – i.e. the first and last sentences in the abstract. So, when I came across two similar articles in the past few weeks with dramatically different conclusions, I decided my ‘just the abstract’ approach wasn’t cutting it and I needed to look further.

The articles were:
Recognizing our Resources

All of these feats, even during economic hardship, cannot be achieved without the determination and efforts of our amazing office staff (Rebecca Tunncliffe, CEO; Stephanie Dutto, Executive Assistant; Suzanne Geba, Member Services and Technology Lead) and our contractors (Deb Monkman, Librarian; Alison Hoens, Knowledge Broker; Bev Holmes, Communications, and Andrea Reid, Education Manager). Of all these amazing people, I would like to pay special tribute this issue to the person that had a special impact on me in my early days with PABC, and is the longest service member of the team — Stephanie.

When I joined PABC for the first time back in 2004, I did so (although not so proud to admit it) out of a sense of obligation. I was not aware of the services that the association would bring to me or the many activities that occur behind the scenes to keep physiotherapy a strong profession in BC. When I phoned the office to inquire about membership, it was Stephanie that gave me the distinct impression that she would bend over backwards if necessary to expedite my membership process and gave me a first glimpse at all the benefits that I would come to realize with my membership. I was so struck by this first contact with PABC that I decided to write the CEO (Rebecca, who I hadn’t heard of at the time) to tell her what an amazing person that she had in Stephanie. I know that Rebecca agrees with me, recently promoting Stephanie from Member Services Coordinator to Executive Assistant!

I am still new to the President role with PABC (April 2009 I took the reigns from Meena Sran), so I want to spend some more time getting to know the staff who are the key drivers of our mandate and initiatives. To that end, in early December I invited Stephanie to lunch in the PABC neighbourhood.

Stephanie celebrated ten years with PABC in September, having been with us since 1999 as the Administrative Assistant, then the Administrator and Member Services Coordinator. Before her two daughters Soraya and Analisa were born, Stephanie worked full time, and has since been working three days per week. With both girls being in elementary school next September, she plans to increase her time with us to four days per week.

In my view, Stephanie demonstrates many of the amazing qualities that we see in our lovely CEO — her determination to succeed (in her mandate of driving a successful organization) seems to be one of her core values. When asked what she likes best about her job, her response was, “To deliver the very best services to our members, because they deserve no less than that.” Now who wouldn’t want someone like that working for PABC? I also asked Stephanie what she would change about her work with us, and she couldn’t think of anything? Guess that means that we will be fortunate to keep this gem with us for a long time to come!

As Stephanie transitions away from her member service role, she admits that she will miss the contact she has with members on a daily basis (30-40 calls and/or emails a week), but she will still have a significant impact on us all. She will take the lead in supporting Rebecca and the Board in our strategic initiatives and will ensure that your high functioning association continues blazing trails into the future. Please join me in congratulating Stephanie on her promotion, and in thanking her for her decade of devotion to us.

Happy New Year to you all! ♦
president@bcphysio.org

“Stephanie is the perfect team mate” says PABC CEO Rebecca Tunncliffe. “In the nine years I have worked with Stephanie, she has not varied in her positive and focused approach to PABC business. She understands our members, and works tirelessly to ensure that each contact she has is a happy one for our highly respected members. I couldn’t have a better partner in my work, and I am grateful that she makes the office a great place to be.”
The PABC office has a new platinum look that will deliver platinum level service in 2010.

Heading the team is me, your CEO, now celebrating my 9th year in your service. At my side to manage the executive functions is our Executive Assistant Stephanie, now into her eleventh year with PABC. Rounding out the permanent office trio is a new position as of January 1, 2010, the Member Services and Technology Lead; Suzanne Geba, our Librarian from spring 2008 to 2009 who left to pursue a career in multimedia, won the job which is the perfect fit for her talents. Rounding out our team are contractors Andrea Reid who has been our Education Manager for the past two years, Deb Monkman who has been our librarian since July, and Alison Hoens our Knowledge Broker since June (not pictured).

The cover story, The Information Power Trio, explains the roles that Deb (three days per week) and Alison (one day per week) perform. The role that is new to all of us is the Member Services and Technology Lead, which we created in order to enhance member services through the introduction of new technologies. This full-time position replaces the administrative role that Estrid Sortti held. We are very excited about the new direction Suzanne Geba will lead us as we seek to support each member throughout the province in as engaging a method as possible. Here we provide an overview of what you can expect in 2010.

Summary of Member Services and Technology Lead Position:
Suzanne will offer new solutions and services to the membership, and recommend the use of technology to improve member services. The PABC Board of Director’s strategic goals for 2010 provide the guiding framework for the role:
1. Recruitment, Retention, Engagement
2. Facilitate excellence in practice
3. Engage partners

Member Services Component: Suzanne will offer fast, friendly, and positive frontline contact for all member inquiries, concerns, and operations, as well as inquiries by the public seeking information on physiotherapy and physiotherapists. By understanding what members want and how best to serve you, she will seek to improve current practices and find new solutions and resources. At its core, the member services component will be about relationship building, dedication to providing excellent member services, and learning about and advancing association best practices.

Technology Lead Component: Suzanne will lead the organization’s technology agenda and seek to offer new solutions by keeping an eye out in the digital landscape. This will include improvements to our website and the Find-a-Physio database, development of a Social Media strategy, implementation of online tools that will engage and improve member experience, improvement of our distance delivery of educational programming and seminars.

To help PABC position itself in the world of new technology, Suzanne will attend a national conference this month in Toronto. For an organization with a small staff team, PABC is taking a great leap in its operations in order to meet its mandate to provide its members with the best in services and resources. PABC is the first physiotherapy association in Canada to dedicate a position to bringing the member services forward in technology, and we expect others to benefit from our learning and resources as we once again forge new paths in our profession.

We will keep you abreast of our progress, so watch for the inventive ways we find to do that!

Come meet the Blonde Squad at the Physiotherapy Practice Forum on Saturday, April 17th at Vancouver’s Plaza 500 Hotel. See page 13 for details.
The Information Power Trio...continued from page one

These articles had many similarities, they both:
• were systematic reviews
• had a similar research question
• had reviewed many of the same articles
• were from reputable sources — one in a peer-reviewed journal and the other from the CanChild website

Unfortunately, despite the similarities, their findings were quite different. One concluded that there was enough evidence to support the use of strengthening exercises for children with cerebral palsy (CP) while the other concluded that the evidence did not support its use. I was perplexed.

My confusion was intensified when I read two letters to the editor about the Scianini et al article that were published in the subsequent issue of the Australian Journal of Physiotherapy. Further questions arose after reading two more articles on the same topic which were published alongside the Harvey et al. article in the International Society for Prosthetic and Orthotics (ISPO) 2009 Cerebral Palsy Consensus Report. I turned to two PABC supports to help me sort out the confusion: the PABC librarian, Deb Monkman, and the Knowledge Broker, Alison Hoens. Together they helped me to explore how there could be such conflicting evidence. Alison kindly offered to shed some light on reasons why there can be conflicting evidence and Deb helped me understand the process of searching for the highest levels of evidence.

PART B: The Knowledge Broker’s perspective: Why evidence can sometimes be conflicting

by Alison Hoens, MSc, BScPT, Physical Therapy Knowledge Broker (PABC, UBC, BC RSRNet), Clinical Associate Professor (UBC), Physiotherapy Clinical Coordinator (Providence Health Care)

Tasha has astutely highlighted a frustration that many of us share in our quest to provide evidence-based practice (EBP) — the disappointment, and sometimes aggravation, when we find contradictory evidence in the literature. Typical responses include: How is it possible for two analyses of the evidence to arrive at opposite conclusions? Why can’t there just be one right answer? Or, if there have been several experiences of reading conflicting evidence, one may even contemplate never reading another article again!

The good news is that there are a number of possible reasons that explain, and ultimately help us navigate through, the valley of confusion. Here are a few questions to ask yourself as you read systematic reviews or meta-analyses which come to opposite conclusions:

• Did they ask the same question? E.g. What is the effect of strengthening on function? What is the effect of strengthening on spasticity? These, although related, are not exactly the same question and will result in different evidence being collected by the literature search, synthesis and analysis.

• Did both use the same electronic databases to find the articles that they reviewed? E.g. PubMed, CINAHL etc. Each database is like a specific filing cabinet full of a different collection of journals and therefore different databases will include a unique combination of journals. Including additional databases in the search can yield articles that you would have otherwise missed.

• Did they collect the articles from the same span of year of publication? E.g. 1950-2008.

• Did they use the same words to search the databases? Different words (search terms) will locate different articles E.g. ‘strengthening exercises’ will result in some different articles being identified than using the search terms ‘resistance exercises’.

• Did they use the same filters (limits) on their searches? E.g. only articles written in English or with the same level of evidence (randomized controlled trials vs non-controlled trials).

• Did they include the same patient population? E.g. age range, level of severity? Moreover, if the patient population is very heterogeneous (comprised of many subgroups), the effectiveness of the intervention may be ‘diluted’, i.e. the intervention may be much more effective on moderately affected patients than on severely affected patients.

• Were the interventions similar enough? In this case, dosing of strengthening exercise can be highly variable such that even though a group undertook a strengthening program, the dose or intensity may have been insufficient to elicit a strengthening effect and thus the study is comparing a group receiving a placebo dose to a control group rather than a group receiving a truly ‘strengthening dose’ to a control group.

• Were the outcome measures used appropriate? E.g. Are they sensitive enough to detect change? Is muscle strength indicative of a change in functional activity? Is this outcome measure appropriate for this population (not only is it reliable in this population, but does it make sense for this population, e.g. do the majority of patients who are tested either find it too difficult or too hard)?

• Did they use the same process in analyzing the collected articles? E.g. How did they come to consensus if they had a different opinion?

• Did they use the same statistical procedure? Different statistical procedures will give different results. e.g. using an average of the results will dilute the impact of a finding more so than if the studies which have more rigorous methodology were rated with a greater degree of impact.

• Were their conclusions reasonable? E.g. Did the authors restrict their conclusions or extrapolate their findings to a wider population than that represented in the articles they analyzed?

The take home message is ‘the devil is in the details’. A careful examination of the details will quickly reveal why the conclusions were different although the topic appeared to be the same.
Another important take home message is that publication of conflicting evidence often leads to controversy. Controversy provokes other authors to send a letter to the editor about the article and then the original authors are asked to respond to the criticisms. Reading this series of letters often highlights the reasons why the results are conflicting.

Finally, perhaps the most important strategy to employ when confronted with conflicting evidence is to incorporate all three components of EBP: (1) the best evidence from the literature, (2) your clinical experience and (3) your patient wishes/values. Each of these three components needs to be factored into clinical decision-making in order to truly be providing evidence-based care.

PART C: The Librarian’s perspective: how do I find systematic reviews (SR) & meta-analyses (MA)?

by Deb Monkman, MLS, BSc, PABC Librarian

How can your PABC librarian help?
Finding the highest levels of evidence — in the form of systematic reviews (SR) and meta-analyses (MA) — is something I'm often asked for when doing a literature search. Let's review how to find these types of publications using the resources in the eLibrary on the PABC members-only website. It’s easier than you might think!

What is the difference between a SR and a MA?
For both a SR and MA, the authors search all of the evidence on a topic, select studies which meet the criteria for their review, assess the quality, and combine the results. It’s like going on a shopping trip for coats with criteria in mind — long, blue, wool, and under $200 — and examining only those coats matching your criteria! If the outcome measures used in the selected articles are identical (e.g., all articles used the same tool to assess strength), the results of the separate studies can be pooled together statistically — this is a MA. In a SR, the outcome measures used in the selected articles are different and thus the data cannot be pooled together. Over time, SR and MA may be updated with new information as more studies are published.

Where are SR and MA published?
I circulated the Scianni article to members because I found controversial reviewer comments on the Rehab+ site. Rehab+ is a database of journal articles that includes reviewers’ comments and quality ratings. So I wasn’t surprised when Tasha said she recalled seeing a contradictory article on this same topic! After some sleuthing, we found a summary of the Harvey article on the CanChild website, while the original article was found within a 312 page unpublished Web document from ISPO! So my first rule is: there is no single source for MA & SR. An article may be unpublished, like Harvey, or published as an article in a journal, like Scianni, and indexed in one of many databases — or not!

Which databases? Search Cochrane, Medline & CINAHL, & PEDro
First, search The Cochrane Library. It is a database of systematic reviews that are often referred to as “the gold standard for evidence-based practice.” Should you stop your search after finding a Cochrane Review? After reading Alison and Tasha’s story, you’ll better understand why you will want to search further! Together with Cochrane, Medline and CINAHL will cover much of the published journal literature relevant to physiotherapy. One other database that can be useful is PEDro, because it is physiotherapy-specific. You will find great overlap with Medline and CINAHL, but also some unique articles. All of these databases are available on the PABC members-only website and are generally sufficient for your clinical needs. However, for comprehensive research, consider other databases as well.

To find SR and MA, use “limit to publication type” in Medline and CINAHL
Do a search on your topic in Medline or CINAHL. Then use the "limit to publication type" feature of your database to limit to systematic review or meta analysis. Unfortunately, it’s not completely straightforward. For the purposes of most clinical queries, I suggest using publication type. However, for thorough research, use predetermined “hedges” (search strategies). For details of which terms to use in which databases, and for instructions for finding SRs in the different medline interfaces, see Table 1 in the full article posted on the Members Only Site/What’s New at www.bcphysio.org.

Can’t I just combine my search with the keyword “systematic review” or “meta analysis”?
No. Here’s why: I searched Medline and compared limiting to publication type to a keyword search. The results are:
- Search: physiotherap* or physical therap* (keywords)
  - Limit to publication type meta-analysis = 97 articles, OR
  - Combined with keyword meta-analysis = only 83 articles (and if you use all the variant spellings meta-analysis, meta-analysis, metaanalysis = 88)
As you can see, you’ll get better results searching in the publication type.

What if I can’t find a SR or MA?
If you can’t find a SR or MA, you can search for randomized controlled trials and other lower levels of evidence, or for a general review article. This will help you to understand what the state of the evidence is on your topic.

How can I learn more?
Be sure to check out the Learning Resources in Physiotherapy & EBM section of the eLibrary (under Tutorials & Training) on the PABC members-only Web site for information about evidence-based practice.

PART D: Putting it all together
Tasha, Deb and Alison created a table that compares the processes utilized in the reviews by both groups of authors. The table can be found in the full article posted on the Members Only Site/What’s New at www.bcphysio.org.
Living with Brain Cancer - part 1
by Grant McLean, BSR

This is not a scientific article.
As a UBC (BSR'77) grad, in full time physiotherapy practice since, this tends to occasionally beg the question of “Where did 32 years go?” Having been an owner/ partner of a clinic in Langley for 20 of those years removes some of the mystery. As does parenting of teenagers, and living an active, engaged life. As with most of us, I have continued to take weekend courses, read every article of interest, trying to keep current and moving forward.

A rather different way to wake up is on the Neurosurgical floor of VGH, with Dr. Gary Redekop sitting at the foot of the bed, advising me of the need for virtually immediate brain surgery to remove a “tangerine” sized tumor from the Left Temporo-Parietal-Ocipital region. The surgery was successfully done the next day, and I was discharged home four days later, fully under my own steam, with minor deficit — a Right Homonomous Hemianopsia.

Anyone who has sustained neck trauma of the sorts that fill our clinics, including we practitioners, is guaranteed to be troubled with headaches, usually mechanical and treatable. Having had 3 MVAs over a ten year period, as well as a couple of concussive knocks, a headache was never a signal of danger; a bit of postural smartening up, possible some manual therapy and Tylenol, and all gone. A basic set of X-Rays were normal, expected lower cervical early changes, plus some thickening at C2/3. All this to indicate some investigations of basic neck pain, stiffness, and headache were being done.

In May 2009, after an unskilled entry into my vehicle resulted in sharply striking both R L sides my head, headaches and neck stiffness became daily but variable, in nature, degree and duration. As we were getting ready to depart on a month long family vacation to Ireland, the extra work at home and clinic to prepare seemed enough reason to feel as I did. Some manual RX plus increased frequency of T2s seemed sufficient, as there were no neurological signs/symptoms, nor reason to suspect there might be. But there was the vision thing…

At least two months prior to the car door episode, I had been in for an eye examination as I felt my progressive lenses were not as helpful as they once were. A bit of increased blur in my right eye plus my reading speed seemed slower, almost to talking speed; this seemed to be at least related to the right eye status, and hence the eye exam. I received the new glasses three weeks before departing for Ireland; I was unable to get used to these, and they did not help matters, so after almost three weeks of trying to adjust, as progressive lenses often do take time, I made arrangements to have my eyes retested after our trip.

We departed for Ireland July 17th, with a four week plan to drive the entire country, Dublin to Dublin. Five days into the trip, I vigorously blew the left front tire on the rental car against an ancient rock wall on the Dingle Peninsula. Within three days, there was a sharp increase in all facets of the headache, with a bit of an accompanying sense of swelling around my eyes similar to a sinus infection. Ice packs and more T2s were adequate to allow an otherwise great holiday, driving another 2,000 kms around Ireland. By week three, at risk of divorce, we decided to turn the vehicle in and use bus, train and subway for the balance of our journey; headache grouchiness combined with my apparent diminishing ability to follow directions (“Did you not SEE that bus coming towards us on your right side?”).

I went into a walk-in clinic in Dublin, prior to the final few days in England, but with no truly discernable positive neurological S/S, Meds were provided, with the advice to consult my GP once back home. Again, more knocks to the head of someone with an established neck and concussion history seemed to fit the clinical picture.

By the time our plane landed at YVR, I was not at all well, and unable to take in any nourishment; my wife, Carol, was standing in the airport with two teenaged daughters looking for their beds, and Carol’s 85 year old mother. The YVR first aid team called for an ambulance, and I went straight to Richmond General Hospital, and had a brain CT scan within two hours, revealing a “large mass” discovered in the L Temporal area needing more investigation, meaning immediate transfer to VGH directly onto a Neurosurgical floor, which took place within the next hour. The first of many neurological work-ups was done within an hour of arriving at VGH (now 11:00 PM Vancouver time), which brings it to the next morning and the diagnosis of Glioblastoma and scheduled urgent surgery. The MRI indicated a massive tumor involving three lobes; parietal, temporal and occipital. On August 17th, a Left Occipital lobectomy was carried out, with as clean a removal of a tumor as the surgeon felt was possible, and his tone was quite encouraging.

Right form the start, even in the dialogues between surgeons and residents, the emphasis was placed on varying things I appeared to have/not have in my favor. The neurosurgeon was very confident in having removed all the tumor; within the hour of speaking with the surgeon, his resident spoke to me about all the lab work waiting to determine the specific type of cancer it was. The resident, however, was more direct in her diagnosis of GBM, a stage 4 Malignancy, which would now require six months of chemo and radiation as well. Sporting a new bald look, and 16 staples horseshoe. I was discharged home; there would be a waiting period of five weeks before RX would begin. The literature supports RX (combined Radiation and Chemo Temozolomide in a pill form), but once the radiation was underway, I understood the need to wait.

In part 2 appearing in the Spring Directions, I will review the Chemo/Radiation period, primarily to highlight how fit and active an individual can actually be during this phase; also, the implications of having been told I cannot drive for one year, or perhaps never again. And my current plan to try a gradual return to very part-time work, possibly by mid-December. ♦

Grant McLean has been a practicing physiotherapist for 32 years in BC, a profession he remains passionately interested in. He owns Langley Physiotherapy, www.langleyphysiotherapy.com, www.grantmclean.com. The current survival rates for this stage 4 cancer (Glioblastoma Multigorme) is 1 year.
OSCAR — A Free Electronic Medical Record

by Edwin Betinol

Last June, I celebrated my 10th year working as a physiotherapist. What better gift to give oneself than a brand new, shiny clinic? Being six months in, sometimes I wonder. I’m thinking it would have been easier just baking myself a cake.

We decided that an electronic medical records system (EMR) would be an essential component to our service. This decision was reinforced when I thought about the ten years of data sandwiched in a netherworld of vanilla colored folders. The challenge was to circumvent some primary known issues associated with delving into the electronic domain. Those were:

1. Cost
2. Vendor lock-in

**Cost is obvious**. My clinic started as a one man show. Is there a cost-effective system that can be utilized by the smallest functioning unit in private practice? Does this system also have the capacity to expand to suit growth and added personnel? Is there a one-time fee? Is there an annual licensing fee? Is there an additional fee when other professionals are added? What are the hardware costs?

**Vendor lock-in is an extremely important issue**. We have to maintain our charts for at least seven years. Is there any guarantee that the software company will even exist in seven years? If the company closes operations, would it be possible to transfer the data onto another EMR? Companies will often have the data in a format that is only compatible with their software. If the software company folds or if the clinic chooses to change software providers, the accumulated data could effectively be lost.

**OSCAR is an Open Source Clinical Applications Resource**. In 2001, the OSCAR project was started by the Department of Family Medicine at McMaster University with the objective of producing a state of the art web-based EMR to support diverse academic and clinical functions. Although primarily directed to physicians, the OSCAR platform was easily adapted for use in the physiotherapy realm.

**OSCAR is a Free/Open Source Software (FOSS) product**. This means that the software can be downloaded freely by anyone and the source code is distributed with the software so that **peer review and collaboration** can take place.

This is an extremely important feature of this program. In essence, this means that I don’t have to buy the program, nor am I obligated to pay monthly or yearly fees. The available source code essentially means that if you have the resources or capability, you can customize this program for your or the community’s needs.

**So how do I use OSCAR?** OSCAR is a Web-based EMR which means that I can access my information anywhere I can find the internet. The client’s chart can be adapted from a simple treatment record to an educational tool. I am able to link photos, videos, forms, diagnostic imaging and web links to the client’s record.

**Is billing through Teleplan possible?** In the initial stages, we were able to bill both WCB and ICBC through this software. There were technical issues that did not allow us to bill for MSP clients. Another physiotherapy clinic signed on to using OSCAR. A member of their technical support team was able to create a fix that modified the billing module to allow us to now bill for the MSP clients.

**Free does not mean without costs**. In reality, most of the costs that are incurred are low compared to long term licensing fees associated with other EMRs. The program set up can be quite technically involved as this program is Linux based (this is another story).

There are options with how clinics approach the technical requirements.

Having computer savvy friends is extremely beneficial. Additionally, there are recognized support providers that can offer more formal service and customizations. And lastly, the Oscar User group in BC is a highly active forum that provides a great environment for discussion and solutions to issues that might arise.

**OSCAR is not perfect**. The open source nature of this program provides an environment that fosters collaboration between its users to continually improve its function. It has been designed by clinicians for clinicians. This is what makes OSCAR so valuable.

If you have any questions about the OSCAR project, please visit the OSCAR user group site www.Oscarcanada.org or contact me; I can be reached at eddy@thejointphysio.com.


Eddy has been busy with two fundraising events in recent months — he shaved his head of mid-spine length hair for “Movember” raising over $5000 for prostate cancer and being number 2 individual fundraiser for BC. See his before and after YouTube videos at his site www.shaveeddyshead.com. He was also involved with an extreme fund raising event in September called The 850 Race www.the850race.com where he ran the event and provided his professional support to runners who attempted to run all 850km of the rugged Bruce Trail in just six days; they raised over $110,000 for Healthy Kids International, an initiative of The Hospital for Sick Children to aid kids in developing countries.
Private Practice Directions

by Perry Strauss, BHScPT, MHA, Business Affairs Committee Chair

Is your Operation Competitive?

In the fall 2009 Directions, we discussed metrics and how one might evaluate their clinic’s operation to determine if it was successful. One of the main challenges in this approach is the availability of industry benchmarks to compare to. In many industries, companies anonymously share information which creates a database of metrics for which individual companies can access to determine how well they are doing amongst their competitors. In the Physiotherapy world, we have essentially created the same type of database. It is a byproduct of the Cost of Business Survey (COBS) that was recently completed in 2008.

The information within the COBS is useful for individual clinics to determine how they compare on items such as:

i) Revenue per square foot,
ii) Visits per patient episode,
iii) Admin expenses as a percentage of revenue.

When reviewing one’s revenue per square foot, many questions arise that, if answered properly, could save an operation significant expense and effort. Consider a clinic whose current revenue per square foot is under the average for similar clinics in a similar region, but also feels that they do not have enough beds or space to accommodate more business. It is not an uncommon consideration amongst clinic owners, with staff agreement, that more space is needed to accommodate busy periods. Space lease costs are the most significant expense outside of therapist and staff costs. Clinics that have higher than average revenue per square foot have entertained utilizing their space in the evenings and on Saturdays. They have also engaged other professionals such as massage therapists, exercise instructors or kinesiologists, and occupational therapists to bolster revenue by expanding services. Some of these therapists perform job site visits and return to work coordination services that do not even take up valuable in clinic space. The cost of moving and expanding may far outweigh the cost of reconfiguring current space to maximize beds utilization, triaging patients not requiring a private room to a spot in the gym, and/or encouraging patients (and therapists) to come outside of peak hours.

Initial assessments dictate the potential revenue that a clinic can obtain. It is only potential revenue though as the average number of visits per patient episode varies greatly among clinics and interestingly, therapists as well. The average number of patient visits nationally is approximately 7.5 per episode. Lower than average visits may reveal an opportunity. Further investigation may find that patient goals for recovery and prevention of further episodes are not fully explored resulting in fewer visits.

Administration costs as a percentage of revenue can be real eye opener to understand if your staff and systems are functioning as well as the competition. Spending some time observing the functions of the office administrative team can be helpful to identify inefficiencies. It is surprising how many things are done just because ‘that’s the way I was taught when I started.’ The comparison on this metric is challenged in a number of ways. First, the clinic that is growing may experience step wise growth in admin costs that will make the comparison look very good for a period as growth exceeds admin capacity. Likewise, when admin support is added, capacity may exceed growth causing the clinic to appear to have a higher than average cost of admin relative to revenue generated. This is usually moderated if one looks at revenue for the year. However, the earlier savings can be identified the better. Another challenge to a straight comparison on this metric is the fact that admin duties can be different from clinic to clinic. Activities such as patient reminder phone calls, progress reports, and typing may not be consistent from clinic to clinic. Nonetheless, a periodic comparison on this metric can mitigate any unnecessary costs.

The COBS data is available on the member’s only website. The clinics that participated in the survey received their individual data in a report with comparisons to aggregate data.

Perry Strauss is the Vancouver Regional Manager of Great West Life Assurance Company.

Media Momentum

In December, CPA began production on its first ever TV ad, and since Hotshop (PABC’s ad firm headed by our highly esteemed Ron Blouin) is in Vancouver, the work was done here. PABC recommended a number of local physios, and the following were able to free their schedules at the last minute for a weekend commitment to a photo shoot at the Treloar clinic: Kerry Maxwell, Meena Sran, Carol Kennedy, Chiara Singh, Rick Celebrini, Mark Borslein, Greg Bay and Tyler Dumont. The ad is scheduled to launch this month for the Olympics.

The most recent media tracking shows 51 physio articles throughout the province in papers and on CBC radio over a 3 month period, reaching over 6 million people. Most of these are accounts of activities by our members in research, practice news, and sports physio. This does not include our TV ad. The incredible news on that front is that Global TV gave us 301 bonus ads from June through September, for a value of $135,668...gratis!

Board of Directors Changes

PABC welcomes Dr. Bill Mackie as the new External Director, replacing the retired Dr. Stan Leete. Watch for Dr. Mackie’s bio in the spring Directions. Jason Coolen replaces Kirby Epp as the Private Practice Liaison. See the updated Board list on page 24.
WorkSafeBC Update

by D. “Scotty” McVicar, PABC’s WSBC Liaison

The past year has been a busy one as liaison between PABC and WorkSafeBC (WSBC). Generally, the position requires answering questions and concerns which are brought forward by members and, where possible, involve the staff with whom I liaise at Health Care Services. In a normal year, like the first eight months of my term, there was possibly one email per week at the most to deal with.

In May of 2009, as you are well aware, WSBC changed their computer system. The long term goal of this change was to combine several systems which were working independently into one operating system.

Communication

Prior to the introduction of the new Claims Management system the communication with case managers and entitlement officers slowed as they were involved in training. Since the new system has been implemented, communication between physiotherapists and claims staff has been very sporadic.

We have been advised that some new fixes are being put in place which will free claims staff to return telephone calls, approve extensions and send out program referrals in a timely manner.

Payment of Services

For the months of May, June, July and early August, the payment of our services was drastically compromised by the introduction of the new system. In most areas of the Province, the level of payment of services has improved. There are no doubt individual clinics that are still having difficulty and those clinics should contact the Quality Assurance Supervisors at WSBC who will make every effort to assist in resolving the problems.

Claims Approval

Claims approval for new claimants continues to be a problem in many areas of the province. WSBC recognizes that claims approval is slow at present but, as the individual claims are approved at the local level, Health Care Services who we interact with have limited input other than ensuring that claims staff is well supported.

The Future

WSBC and Telus Health Solutions from Toronto are working on what is called a provider portal. When this vehicle is up and running, it will offer us, as providers, the opportunity to view the main required activities on any claimant’s file. This should make our job much easier and, as this project expands, I believe there will be some excellent features to assist us in the delivery of care to our clients, and also ensure that all information is on file allowing us to be compensated in a timely manner.

The Claimant

At present, claimants know exactly what is happening with their file. They are notified by mail within 24 hours of their claim being approved.

They have the ability through a secure portal to access their file information and review on a regular basis, medical reports, conversations between case managers and physiotherapists and financial information including when their last cheque was sent out.

The claimant is the number one priority of WSBC and they have access to information that we do not.

At all times as physiotherapists, we must recognize that the Association interacts on a very regular basis with Health Care Services at WSBC. There are times that members run into difficulties which we have no control over and problems arise that neither party can resolve immediately. I wish to assure you that we are making every effort to represent you and work with one of our largest payment sources in a fair manner and WSBC’s response has been one of support and co-operation.

Scotty McVicar owns Oceanside Physiotherapy and Work Conditioning Centre in Parksville.

ICBC Update

submitted by Marj Belot MScKin, B.Sc.PT, FCAMT, CAFCI, PABC-ICBC Liaison

The Business Affairs Committee met November 29, 2009. A number of issues were discussed including ICBC fees and direct access with ICBC. PABC has initiated discussions with the provincial government regarding changes to government regulations that would be necessary to effect change regarding these issues. This is likely to be a slow process and therefore there is nothing else to report regarding these issues at this time.

A question was received from a member regarding the billing process for the CL20 report. ICBC must be invoiced $46 manually as the CL20 is not currently included the Teleplan system.

Another question was received regarding ICBC payment for concurrent physiotherapy treatment and conditioning at an alternate facility, which does not include physiotherapy management. If the doctor agrees that this is reasonable and medically necessary for the client, then ICBC should be covering both. If the client has attended an independent medical exam (IME), then the adjuster will typically follow the recommendation given in the report from the independent medical examiner.

The previous contact person at ICBC has been moved to another position which reduced the flow of information to and from ICBC in the fall. A meeting will be scheduled in mid to late January with his replacement regarding issues of mutual concern.

There is information on the members’ side of the PABC website regarding many ICBC issues. If you cannot find the answer to your question or have other comments feel free to contact me at belotphysiotherapy@gmail.com.

Marj Belot earned her MScKin degree in December. She practices at West 4th Physiotherapy in Vancouver.
Over the holidays, a colleague had to resign from an important PABC task force, citing that the time demands for his job as a manager and physiotherapist for his clinic were already excessive and he needed to focus his energy on his business. This fact reinforced what I had been intending to write about for this newsletter: the idea that a physiotherapist, whether in private or in public practice, has a personal responsibility to the success of his/her workplace.

This is obvious for a clinic owner who must devote energy towards running, growing and enhancing the business practice environment, as well as seek innovative ways to provide the best possible services to the broadest clientele base if the clinic is to survive the current health care reforms and fiscal constraints.

In public practice, I would like to suggest that physiotherapists have a similar obligation towards enhancing the organizational health care system that they work within and I would like to touch on a few ideas that support this notion.

Spreading Good Ideas and Best Practice

We know and understand the evidence that supports a change in how we deliver services. Ideas whose time has come include:

- inter-professional models providing multi-dimensional care;
- team-based services within an office or community setting, and
- patient self management and empowerment through education and support.

Physiotherapists throughout the province are involved in isolated examples of exceptional care, in innovative pilot projects, have run successful therapeutic programs, or have acquired individual levels of expertise that have made a significant contribution to improvements in population health and support current health care reform initiatives focusing on primary health care and prevention. Most of us have also likely identified serious flaws in the organization of care, have thought of ways to improve a process, or understand where a system change could result in improved practice.

Seth Godin, a popular business writer, identifies the need for every individual in an organization to share in the responsibility to make noise, make change, and make a difference. The reason this doesn't happen as often as it should is that it feels risky. He argues that the era of corporations becoming rich at the expense of communities must end and that individuals within an organization can engage in the concept of “gifting” as an art form where work becomes a creative problem solving environment where collectively change is sought out and embraced in order to improve the system overall (Godin, 2009).

An important strategy to promote this notion is to build opportunities to share and learn from people who are tackling the same problems and have already found a “best practice” solution. Knowledge sharing internally and externally and a willingness to learn from others (i.e. steal their ideas) is critical to spreading good ideas and good practice.

As professionals working in a public environment, do we not have a societal obligation to implement good ideas, support positive system change, spread innovation, as well as to identify faulty practice and speak out when we see a need for improvement? This obligation is tied to our role in treating not only our patients but in helping to create a healing environment within the culture of our health care organizations.

The Push and Pull of Organizational Culture

Innovation, best practice or good ideas will not spread, or be adopted, if the existing social and cultural environment, held together by cultural norms and individuals values and beliefs, is not considered. An organizational ‘push’ for change will more likely succeed if it aligns closely with the health practitioners’ sense of justice for their patients and personally held values and beliefs, thus creating a ‘pull’ for driving the change. When a change proposition makes an irresistible emotional and logical argument that fits with a clinician’s values, beliefs and work experiences, it has the possibility to mobilize people into driving change forward (Penna, 2009). Examining the cultural environment and communicating along its existing knowledge translation pathways or reinforcing or expanding these links is a key part of successful spread.

Working within a large complex health care organization, physiotherapists may become dissatisfied when there is a lack of opportunity to contribute to
change initiatives or make a meaningful contribution to how our work is done. This idea, when combined with the fact that health care staff will tolerate a 10% increase in their workload if they believe an idea will benefit their patients, emphasizes the importance of synergy between organizational push strategies and frontline, grassroots emotional pull for improving quality of care.

“The people that do the work must change the work.”

Social Justice
Organizational and system change in today’s health care environment has come to recognize the need to include social determinants of health within its framework of reform. This has led some health organizations internationally to consider social movement thinking as a driver for reform. Helen Bevan, director of Service Transformation within the NHS Institute for Innovation and Improvement, writes that in the field of change management, people are more likely to change what they do when they are shown a truth that influences their feelings. For example, physiotherapists in public practice, especially in pediatrics and community care, often experience challenges to their sense of social justice which could be harnessed to mobilize their own internal energies and drivers for change. Do we have a responsibility to resolve the conflicts in our sense of justice?

In healthcare, social justice means a fair distribution of resources that can impact one’s health and well being. This includes food security, housing, poverty, literacy and so on. As a result of this focus, healthcare professionals must collaborate, not only with other team members, but also with community agencies and social groups that work to alleviate the social disparities in their own communities (Ethics in Practice for RN’s, 2009).

The Canadian Physiotherapy Association identifies one of its professional responsibilities to society as follows: “Physiotherapists shall recognize their responsibility to improve standards of health care.” This can be taken broadly to mean that we should be aware of our potential to contribute to organizational and systems change and that the status quo is very rarely an acceptable place to stay. We need the courage to make a personal stand for what is right and put ourselves out there - in that place of discomfort and risk - to resolve the dissonance we feel between what we believe and value, and what we know as the norm or common practice. Our professional obligation perhaps should extend beyond direct patient advocacy with which we are so familiar, and into the realm of social justice and systems change.

Summary
The work environment of public practice physiotherapists is changing in order to better provide the health services expected by society and the general public we serve. We must actively participate in these changes to successfully create a meaningful work environment for ourselves and a sustainable health care system for society. As professionals, we are trained to handle work that is autonomous, challenging and self-developing in order to fulfill our mission to provide patient care in the best possible way. The mission of health care organizations is the same. Our professional responsibilities in public practice should therefore include a commitment to understanding the push and pull process of change, how to spread good change initiatives and to advocate for change that improves the social fabric we work and live within.

Our role in PPAC might include developing tools that support these professional responsibilities, including linkage and exchange infrastructure with the goal of spreading best practice and positive change.

“We must become the change we want to see.” Gandhi

Susanne Watson is the chair of PABC’s Public Practice Advisory Committee, and can be reached at Susanne.Watson@northernhealth.ca.

References
Helen Bevan on social movement thinking: a set of ideas whose time has come? Institute for Innovation and Improvement. http://www.institute.nhs.uk/quality_and_value/introduction/helen_bevan_on_social_movement_thinking%3a_a_set_of_ideas_whose_time_has_come%3a.html

Board of Directors
Nominations
Each year, half of the Board Director positions are open for nomination. The four regions that have terms expiring this year are Fraser Valley, Greater Vancouver, Kootenays, and the North West. Members are welcome to seek nomination by February 15th from two peers in their region for the regional Director position. Current directors of the first three regions listed are interested in renewing their terms, and further nominations would therefore be up for election. Contact Rebecca at rbt@bcphysio.org

Winter 2010 • Members Make the Association
Functional Electrical Stimulation Treatment of Foot Drop, a Wireless Solution

by Heather Branscombe, BScPT MBA for Rehabilitat

We at Abilities Neurological Rehabilitation have recently teamed up with a California medical device company, Bioness, to help our patients recovering from stroke, traumatic brain injury, multiple sclerosis, cerebral palsy, and incomplete spinal cord injury to achieve more mobility, independence, function, and freedom.

The NESS L300 System accelerates and complements our traditional therapy. We can maximize rehabilitation of foot drop by using the device between therapy sessions, and we even encourage patients to purchase the NESS L300 for home use.

The NESS is at the forefront of innovation in Functional Electrical Stimulation (FES) therapy for foot drop. The system is wireless, portable, and programmable, and the therapist can fine tune the settings while the patient is actually walking. The system has three components: a gait sensor worn in the shoe, a wireless stimulating leg cuff worn below the knee, and a clinician-programmed control unit. When the gait sensor detects “heel off,” it sends a message to the leg cuff, which then stimulates the leg muscles to lift the foot accordingly. The advanced gait sensor technology allows patients to achieve a more-normalized gait on changing terrains and at varying speeds.

So far, we have successfully used this device with both children and adults with neurological challenges. The range of conditions includes cerebral palsy, stroke, multiple sclerosis, traumatic brain injuries, as well as incomplete spinal cord injuries.

It is most exciting because unlike traditional bracing for these populations, such as with ankle foot orthoses, this works on a motor re-integration model, which allows us to achieve better functional outcomes.

In fact, I was so impressed with this technology that I now also work with Bioness as a Clinical Specialist to help both therapists and orthotists integrate this technology into their own practice.

I would love to see a fuller integration of FES into neurological treatment: children, adults, in-patient, out-patient and in the community. The evidence is already very clear for some populations (such as post-stroke), and is gaining for many other populations. I would be happy to talk to other therapists about my journey into the world of FES and how it can help your practice and/or your clients. Find more information on Bioness at www.bioness.com or contact myself directly at 778-880-0944 or www.abilitiesrehabilitation.com.

At Heather’s clinic Christmas party, the team undertook an activity to honour both the upcoming Olympics as well as the Olympian gymnast PT student on placement, Kate Richardson. They re-created an Inukshuk, which means “you are on the right path.” As a way to get excited for the upcoming Olympics, Heather challenges other PT teams to create their own Inukshuk. Who better than PTs to help people on their own path to better health?

Post-Natal Info Flyer Initiative

Diane Lee and Associates initiated the development of an info flyer for new moms being discharged from hospital. They worked with PABC leaders in perinatal health (the team is pictured). The flyer provides new moms with guidelines as to what to look for during the eight week recovery period and whether they should consider seeing a physiotherapist. A PABC survey of hospitals discovered that no current information is given to moms, and certainly no physio-informed flyer is available. The new flyer will be made available free to PABC members.
Physiotherapy Practice Forum 2010

Why come to the Physiotherapy Practice Forum 2010?

You are very familiar with the old Annual General Meeting day, and as exciting as that day has always been, we decided to make it even more magnetic. We have dropped the AGM Day moniker in favour of a title that better describes what you can expect from this annual gathering. And so, the Physiotherapy Practice Forum is born.

On Saturday, April 17th from 8 am-6:30 pm, you will enjoy a day of free education, food, trade show offerings, prizes, and updates from both PABC and the College, as we co-host this day that focuses on your practice.

Call for Posters

PABC is pleased to invite your participation in the 1st Annual Clinical and Scientific Poster Session at the 2010 Physiotherapy Practice Forum. The interactive session will take place on Saturday, April 17th from 5:30-6:30 together with our wine and cheese reception. Members will circulate and sip a glass of wine (provided by PABC) while viewing the posters and speaking with presenters, then vote for the best ones.

Abstracts based on unique clinical cases and all aspects of physiotherapy research are being accepted. We encourage submissions from the clinical world, as well as from graduate and MPT students — there will be prizes for the best student poster (PhD, MSc, and MPT) and the best clinical poster. **All abstracts must be submitted electronically via online submission by February 25, 2010. Online submission will open on February 11, 2010.**

This is an excellent opportunity to participate in a peer-reviewed adjudication process – a great addition to any CV and generally to professional bragging rights.

For more information, contact Lois Lochhead, PABC Board Director for the Central Interior/NE Region and instigator of this new initiative, at lois.lochhead@shaw.ca.

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PHYSIOTHERAPY PRACTICE FORUM

Co-hosted by PABC and CPTBC

Saturday, April 17, 2010

Plaza 500 Hotel, Vancouver

7:45-10:45 Registration, Trade Show, Breakfast (to 9am)

8:00-9:00 *Education Session: Physiotherapy Pain Management: evidence on positive neuroplastic changes – Neil Pearson*

9:00-10:15 PABC Annual General Meeting and Awards Presentation

10:15 – 10:45 Coffee break and Trade Show

10:45 - 11:45 CPTBC Annual General Meeting

11:45-1:00 Buffet lunch and Trade Show

Clinical and Scientific Posters on Display

1:00-2:30 *Education Session: Tips for Managing Your Challenging Patients*  
Part 1: How to start when you can't get to Yes: Getting consent from the cognitively impaired, and patients who'd rather stay in bed – Martha Donnelly, MD, CCFP RCPSC, UBC Family Practice and Psychiatry  
Part 2: How to stop when you can't get to No: The right way to discharge – Derek Mah, LLB, BScPT, Murphy Battista Lawyers

2:30-3:00 Coffee break and Prizes

3:00-4:00 *Education Session: CPTBC Quality Assurance Program*

4:00-4:30 PABC Practice updates - Private and Public initiatives

4:30-5:30 *Education Session: Contraindications and risks for Electrophysical Agents – Alison Hoens*

5:30-6:30 *Education Session: Clinical and Scientific Poster Presentations*  
wine/cheese reception

**All this - all free!**

See insert to register and for details on the education sessions
At press time, just 20 days. By the time you read this — just a few days. It’s hard to believe the Vancouver 2010 Olympic and Paralympic Games are so close. It seems like just yesterday I was alerting all of you to the call for medical volunteers. But in fact, that was exactly two years ago!! And did we ever step up to the plate! Congratulations to each and every one of you who applied and have offered up your time and valuable skills to such an amazing event. We have approximately 95 physiotherapists working and volunteering at the Olympic and Paralympic Games, with over half of them being from BC.

A number of our BC Sport Physios, including myself, are involved in the games as Venue Medical Officers (VMO) or Supervisors (VMS). Our roles are to assist in the coordination of the medical teams responsible for any and all medical related events at each venue. For example, at the Richmond Olympic Oval, I will be working alongside the VMO (an ER Physician) and our 23 person medical team (a small team in comparison to the 55 and 90 member teams at Canada Hockey Place and Cypress Mountain respectively)!. Our team consists of five Sport Medicine Physicians, four physiotherapists (Duane Brousmiche, Thomas Tran, and Steve Witvoet from BC), four athletic therapists, one nurse, four first-aiders, and five paramedics. The physios at our venue are all certificate and/or diploma Sport Physio and will thus be specifically involved with Athlete Medical. Trained in acute, on-field response to a medical event, they may be stationed on the field of play responding directly to an athlete injury on the ice, or they may be in the Athlete Medical room responding to and assisting with any medical needs of the athletes as well as the venue workforce.

Some of the other Sport Physios in our province acting as VMO’s or VMS’s: Wendy Epp (Cypress Mountain Freestyle Skiing); Terri-Lynn Fraser (Short Track Speed Skating); Trish Hopkins (Curling); Zenya Kasabuchi (Sledge hockey); Paige Larson (Figure Skating); Ron Mattison (Men’s Ice Hockey); Susie Mortensen (Whistler Olympic Park) and Nadine Plotnikoff (Women’s Ice Hockey). Randy Goodman and Greg Bay are the therapy supervisors at the Vancouver and Whistler Polyclinics respectively. And keeping and Nadine Plotnikoff (Women’s Ice Hockey). Randy Goodman and Greg Bay are the therapy supervisors at the Vancouver and Whistler Polyclinics respectively. And keeping

Sport Physio BC Update for PABC — Go Canada Go (and BC Sport Physios)!

by Kimberly George, Chair SPC-BC

Go Canada go! for stories and updates on what all of the BC Physios are doing during this incredible Therapy Services for VANOC. Keep your eyes and ears open over the course of the games and stay tuned for stories and updates on what all of the BC Physios are doing during this incredible event. Go Canada go!

Olympic Flame Relay

Tyler Dumont will be carrying the torch on Feb 10th as one of the last relay runners honoured to perform the historic event. Tyler was nominated as UBC Physio Department’s torchbearer; UBC-PT earned the privilege in recognition of its equipment donation to the Games. He is running at 3:09 pm on Wednesday, February 10th in North Vancouver. Says Tyler, “I am to run south along Grand Boulevard West from house #1735 to house #1523 (middle of 17th avenue down to 15th avenue). I really look forward to running on behalf of the Department of Physical Therapy. I plan on doing a slow jog since 300m will only take 2-3 minutes to cover.”

PABC Regional Alignment

Following member consultation, two regions have been realigned: the Peace River Liard area is now part of the Central Interior Region (was aligned with the Greater Vancouver region), and the Sunshine Coast area is now part of the Greater Vancouver Region (was aligned with the Fraser Valley Region).

Little Physios

Jason Coolen is a first-time dad. Gabriella was born on December 30th at 4:35 am weighing in at 9 lbs.

Rachel Corbett got to the hospital just in time to birth her second son, Nolan Hans Corbett, on December 20th weighing 9 lbs 3oz, brother to Seth.

Laura Werner gave birth to Erik David Werner, weighing 11 lbs 9oz on October 30th. delivered at home with brother Marinus’ help.

Dan and Tanya Bos (both PABC members) had triplets on October 29th, joining brother Zackary. The two girls are Aliyah Mae and Tanayah Grace, and Joshua Daniel rounds out the gender balance. This has been a very busy year for the Bos’s: in addition to a rapid expanse of their family, they bought Judy Todd’s clinic and re-named it Abbotsford Sports & Orthopaedic Physiotherapy.

Hyman Gee is a new dad with baby daughter, Julia Gee, coming into the world on October 23rd, at 6 lbs 4 oz.

Perry Strauss now has a daughter, Ava Marilena, who arrived 8 weeks early on October 14th, at a tiny 3 lbs 12 oz, joining his two year old twin boys.

David Terlich and Nadine Nemhard (both PABC members) are proud parents of a baby girl, Mya, born on October 5th.

If you are expecting a little physio to come into the world before the April 1st newsletter deadline, let us know at rbt@bcphysio.org.
Professional Development Directions

by Andrea Reid, MSc, Dip. Sport PT, FCAMT, GunnIMS, PABC Education Manager

Your Professional Development Advisory Committee (PDAC) has been hard at work to bring you another year of outstanding education and continuing professional development. 2010 will bring both our seasonal lecture series and two outstanding courses.

Some of you may have noticed that the location of the 2010 lecture series was “TBD”. We are pleased to announce that we will run the Spring Lecture Series “Your Basic Skills Refreshed” in the Main Floor Auditorium at Vancouver General Hospital. We hope this venue will be accessible for members practicing in all areas of Vancouver. For those in outlying areas, consider registering your clinic for the remote ‘group rate’, or signing up as individuals.

We have elected to forgo the first lecture of the year in view of the Olympic Games and will pick up where we left off with Alison Hoen in March. “Hot & Swollen: Ice, US, Laser or IF” will refresh our knowledge of the efficacy of electrotherapeutic modalities in the management of acute inflammation.

The second lecture in the series will update us on the latest evidence for the treatment of tendinopathy, and not just of the Achilles tendon! Alex Scott is a physio and researcher and will help answer our clinical questions about how to manage this difficult condition.

PDAC is pleased to have Dr. Ola Grimsby join us May 15 – 16, 2010 for his course “Lumbar assessment and interventions: a comprehensive, eclectic approach to science, theory and clinical rationale”. This 2-day course will take place in the new Physiotherapy Department at UBC and will allow us an opportunity to learn from this renowned clinician and educator.

Finally, as joint arthroplasty techniques evolve, the patients receiving joint replacements are younger and more active; we need to keep well informed of how best to rehabilitate this group. To help bring us up to speed, orthopaedic surgeons Dr. Bas Masri and Dr. Bob Hawkins, along with physiotherapists Bruce Clark and Cam Bennett will deliver a one-day seminar on shoulder, hip and knee arthroplasty. Mark your calendar for October 16, 2010 and expect registration to open this spring.

Both the evening lecture series and the Ola Grimsby course are easy to register for through the PABC website www.bcphysio.org under ‘Courses/Events’. We hope you will find these events both interesting and useful to your practice. Remember, we are always looking for suggestions and feedback, so please feel free to contact me at education@bcphysio.org with any of your comments. ♦

Andrea Reid is PABC’s Education Manager, and practices at the Alan McGavin Sports Medicine Centre at UBC.

Joke from an Okanagan patient to his physio
Q: why did the snug little bug in a rug go for physiotherapy? A: because he had carpet tunnel syndrome.

Kudos

PABC’s Lecture Series (Heather, put this with the PD page as a sidebar)
I want to thank PABC and the education committee for thinking of me when they envisioned this gait course. Two years ago I never would have imagined where the journey to prepare for it was going to take me. I have been extraordinarily lucky to have something offered to me that has challenged me, invigorated me, given me the opportunity to learn an incredible amount, and provided me with the chance to create something new with Cathy Eustace and Libby Swain (two amazing physios whose paths I may otherwise never have crossed). I am very grateful for this.

And based on the course participants’ feedback, this integration of neuro and ortho is the way things should go. We are not that far apart in our specialties and there is the shared understanding that we treat the whole person. The layer of understanding I have from a new neuro perspective will only enhance my ability to treat my ‘ortho’ patients. I have already changed a number of things I do and look forward to creating an even more effective approach incorporating my understanding of the neural drive underpinning human movement. It is exciting.

Sincerely, Deb Treloar
Advocacy Updates

PABC has undertaken several advocacy issues with the provincial government in the last quarter including the Ministry of Finance regarding the impact of HST on clinic expenses, the Ministry of Children and Family Development regarding effects of cuts to early childhood services, and the Ministry of Health advancing of physiotherapy in new primary health care initiatives.

HST

The PABC contingent of Marc Rizzardo (chair, Fee Negotiations), Scott Brolin (President) and Rebecca Tunnaciffe (CEO) went to Victoria in October to meet with the Ministry of Health regarding the impact HST would have on clinic expenses. The meeting was followed up in November with a letter to the Ministry outlining specific cost implications (an overall cost increase of 2-3%), as well as a list of suggestions for mitigating those costs. The letters are on the PABC Members Only website. While we expect some accommodation, we recognize that the bottom line will be an increase in treatment fees of about one dollar, depending on your clinic business model.

Our Business Affairs Committee will be publishing a members’ guide to managing HST which will include the items HST will be added to, the formula for determining the increase costs for the clinic, and a guide for determining the required increase to treatment fees to accommodate for the increased expenses. Look for this guide in the next Directions newsletter and by email.

Paediatrics

The Ministry of Children and Family Development has proposed a policy review regarding the prescription of orthotics. PABC, together with the College of Physical Therapists, responded to the Ministry with recommendations in November that will ensure our members’ interests will be addressed.

PABC and the PT Paediatric Council responded to the funding cuts imposed on the infrastructure for children’s services announced by the Ministry of Children and Family Development in the autumn.

We asked for accountability in services in the light of administration cuts. We received a letter in December acknowledging our concerns and promising the cuts will not impact the children. We shall see!

Primary Therapist Transdisciplinary Model: The document, after two years of intensive work from the three profession (PT, OT, SLP) task force chaired by PABC’s Kathy Davidson, is done! It is now out for review among the three professional organizations accompanied by a survey monkey to gather the impressions. Next — off to Victoria to deliver the document.

Scope of Practice

PABC has been working with the College to review current practice as it relates to the Health Professions Act’s Restricted Activities. The College will apply to the Ministry of Health to include physiotherapy in those activities which are now restricted but which are in current practice such as those related to wound care, incontinence, diagnostic ultrasound). PABC is undertaking to advocate for referral to a specialist, and the ordering of lab and imaging (x-ray, MRI) tests. We have done the background on these advocacy issues and will begin the consultation process with stakeholders.

Primary Health Care

We have a new task force struck to define a vision for the role of physiotherapists in the service delivery model of the emerging primary health care team movement. Chaired by Tara Pollock, the team includes Carey Adam, Cara Humphreys, Cheryl Lea, Gareth Mulligan, Susanne Watson, Ming Leung, Robin Roots, Susan Illmayer and Rebecca Tunnaciffe. To date, the task force has reviewed and analyzed the current literature, sought BC examples of primary health care initiatives, and drafted concepts for a new interdisciplinary approach to health care in BC. The interesting finding is that there is no existing model for PHC that we can emulate from any jurisdiction in Canada or in the world. The limiting factor for a true primary health care team is a funding model. The current Interdisciplinary Health Networks (IHNs) in BC for instance, are typical in that the physician is covered by MSP, and at times nurses and pharmacists are paid through public funds, but the other potential members of the team (PTs, dieticians, OTs, nurse practitioners, etc.) are not publicly funded.

The task force expects to have a position paper completed by the summer.

Advocacy Kudos

Thanks so much for your help with our practice issues. We really appreciate what the PABC does for physiotherapists!

North Vancouver member

Good on PABC for getting to the Ministry of Finance on the HST issue for clinics.

I was just budgeting for next year and considering that change – mistakenly thinking that there was nothing we could do about it at this point. Thanks!!

South Okanagan member

PABC has gained a member for life, thanks to your advocacy for paediatrics!! I will be sure to let our staff know (and any other PT’s within earshot) that PABC is supporting pediatric members and that this voice can only continue with PABC membership.

Surrey member

I think the letter to the Ministry of Children and Family Services related to its cuts to programs is excellent and the timing is perfect. Thank you so much for PABC’s work and advice.

Vancouver member

What a great feeling it is to have this very collaborative, transdisciplinary primary therapist model project completed. Our work as an interdisciplinary team of PT, OT, SLP integrated various therapy perspectives and we had Kathy Davidson working like a primary therapist; the project itself certainly seems to reflect what this paper is trying to reflect.

OT member of the Primary Therapist task force

Thanks again to Kathy Davidson (PABC) for keeping the project moving along.

A true reflection of what can be accomplished as a collective.

OT member of the Primary Therapist task force
A PABC Library Resource Story

A PABC member recently sought services of the PABC Librarian, Deb Monkman, in seeking available evidence on Faradism, a practice advertised in a local spa. The member told Deb about “an alarming article in my local paper advertising the use of a Eurowave Slimming Machine (a faradic machine) that claimed that lying on a bed with this machine attached to the client’s abdomen for 18 minutes, was the same as doing 200 sit ups and produced a 6-inch reduction in their waist measurements! etc.” The spa was unfamiliar with the abdominal muscles, and could not explain the parameters of the faradic machine or how it was achieving the remarkable results, but it felt the machine was cleared for cosmetic use.

The PABC member wrote to the Minister of Health inquiring about whether faradism is classified as a medical device. The immediate response stated that it is currently being investigated by Health Canada, and likely will be classified as a medical device which requires special medical licensing to be manufactured, sold and operated in this country.

Deb undertook the member’s search for “quality articles on faradism, its effects, and articles comparing the effect of using electrical muscle stimulation to strengthen muscles in conjunction with, versus without, exercise or active participation.” Unsurprisingly, there was no research that supported evidence of slimming. Faradism and electrical stimulation show up in the literature in relation to urinary incontinence, rectal prolapse, its effects on the power of the quads, TMI, and other topics going back to the 1960s.

You can learn about the physiotherapeutic application of electro-physical agents at the PABC lecture/videocast by Alison Hoens March 31st; see back page for details.

Kudos For Deb the Librarian

Wow!! You found exactly what I need! Thank you...my first ever question to the PABC librarian. I read your column in Directions, and will attempt looking more myself too....and yet the life of a sole charge clinic owner means you barely get to check your email each day!
Kootenay member

I am becoming a big fan of your work! Thanks! Whistler member

A big thank you for the job you do for PABC members. Makes our life much easier to have an expert advising on the best resource use considering the varying level of research quality and the inherent problems with not being able to put physiotherapy into a standardized pill form. The availability of the librarian service is a significant reason why I pay my membership dues.
North Shore member

Clinic Considerations: Space Sharing and Shareholder/Partnership Agreement by Jennifer L. Neville, LLB

It is common for physiotherapists to practice in a clinic with other practitioners. This may be done through an employment agreement with a clinic, through a space sharing arrangement, or through a corporation or partnership. In all cases, entering into a written agreement will help limit risk and liability and avoid disputes in future.

What is a Space Sharing Agreement, and Do You Need One?
A space sharing arrangement is one in which two or more independent practitioners share clinic space and treatment rooms. In such a situation, the practitioners may have a common reception area and receptionist but will practice independently of each other and will not share profits. Provided that the relationship between the parties is clear, a party will not be liable for the liabilities or obligations of another party. A space sharing agreement should set out how each party will contribute to all shared costs, and for liability reasons should clearly indicate that the parties are not practicing in a partnership. The following are examples of issues that should be addressed in a space sharing agreement:
1. How the parties will share costs, and the date by which they will make payment to each other or to third parties;
2. Indemnity provisions for claims related to the lease, shared employees, and other claims;
3. Times of use for treatment rooms, and other rules for operation of the clinic;
4. Termination and dispute resolution provisions.

Why Have a Shareholder or Partnership Agreement?
Where practitioners are practicing together in a partnership or corporation, they should enter into an agreement setting out their rights and obligations. Unexpected issues such as death, divorce, bankruptcy, and retirement of a partner will impact the entire practice and it is important to consider such issues in advance. A Shareholder or Partnership Agreement should address the following issues:
5. Who will have the power to make decisions, and be responsible for day to day management;
6. Who has banking authority;
7. Actions that require unanimous approval of all of the parties;
8. How the parties will share the profits;
9. Non-competition provisions;
10. Restriction on transfer of shares or partnership interests;

Conclusion
A successful practice requires planning. Whether parties practice in a less formal space sharing arrangement or a corporation or partnership, it is important that the parties discuss and agree upon how the clinic will operate and the obligations and expectations of each party. Although there is an initial cost to setting out the terms in writing, it is a small cost compared to the time and expense that could result in the event of a dispute or other unexpected development.

Jennifer Neville is a lawyer with Hammerberg Altman Beaton & Maglio LLP, and can be reached at jneville@hammerco.net
Clinical Education at UBC: a new year and moving forward!

by Sue Murphy, Academic Coordinator of Clinical Education

Many of you will remember the Clinical Education Symposium held at UBC just over a year ago. Many excellent recommendations and suggestions were made at that meeting and, with the start of the New Year, it is time to reflect back and see what changes we have made and where we need to focus our energies in 2010.

Some of the changes made as a result of the symposium include:

- A “new site” package and two recruitment brochures were developed to provide key information to sites and clinicians who may consider taking students;
- A newsletter (*The Globe*, to echo the branding) has been initiated and three editions have been sent out to a broad section of the clinical community (let us know if you would like to be on the mailing list!);
- The *Clinical Education Manual* has been revised and placed on the website so that all clinicians can access the most current information on the program and clinical education policies, procedures and expectations at any time;
- Student expectations have been developed and included in the manual to clarify performance expectations for each level of clinical placement;
- Students are now required to complete an “interprofessional” placement. As many rural placements offer this type of learning, the likelihood that each student will experience at least one rural placement during their program has significantly increased;
- The nine Clinical Educator Workshops were provided in locations throughout B.C. in 2009;
- The email for the placement assistant has been changed to pt.placements@ubc.ca to facilitate communication. This email address will remain the same regardless of internal changes at UBC;
- Increased lead time has been instigated for calls for offer;
- The Provincial Advisory Committee has been formed and has met twice. Membership consists of representatives from public and private sectors in each health authority as well as other key stakeholders and decision makers.

We have also revised and updated our website (as much as the current platform will allow) with the goal of increasing ease of use and accessibility of information to clinicians. More information on the clinical education program and on the changes outlined above can be found at http://www.physicaltherapy.med.ubc.ca; click on “faculty and staff”, then on “clinical education home”, and “clinical education information”, and you will find a wealth of information on the PT clinical education program.

The focus for 2010 will be to increase the diversity and number of placement opportunities for our students, and to build on the success of the student led clinic at Royal Columbian by looking for similar opportunities for clinics in other facilities as well as for other potential options for student involvement in diverse clinics and services. If you have an idea for a different placement model or setting, please send me an email as I would love to hear from you! sue.murphy@ubc.ca.

Happy New Year everyone and I look forward to working with many of you in the coming year! ✶

Internationally Educated Physiotherapists (IEP) Program: Update January 2010

by Gillian Parker

The 2-year IEP pilot program, developed to assist Internationally Educated Physiotherapists (IEPs) in their preparation for the Canadian National Examinations is now nearing completion. The pilot program received funding from the Ministry of Advanced Education and Labour Market Development and ongoing support from its program partners (UBC Department of PT, CPTBC, PABC, VCHA and FHA, and the UBC e-Health Strategy office for program evaluation). The Program began initial development and planning in February 2008 and saw the first cohort of IEPs admitted in July 2008.

The IEP Program has seen high demand from IEPs who have sought support for the National Exam preparation. The program has completed six written and three practical cohorts, and with 44 IEPs enrolled, has far exceeded the initial target of 24 participants. The program has also seen great successes with 100% (17) of IEPs passing the practical exam and entering the PT workforce in BC. The results of the 15 IEPs who sat the November 2009 practical exam are still pending.

The IEP Program has been an exciting and rewarding project for those involved, and with the wrap-up of the pilot project (final report due in March 2010), future planning for a sustainable program is under way for 2010. The sustainable program plans to run on a cost-recovery basis, with government support and assistance from the project partners, and will include support for both written and practical exam preparation through an online technology enhanced learning platform.
The IEP Administration Team wishes to thank those who have been involved in the success of the program over the past two years, including the ongoing support from the government and project partners, the knowledge and expertise from the program mentors and the invaluable assistance from the UBC staff. Stay tuned for further program announcements as the plans for the sustainable program begin to roll out. ♦

From: The IEP Team. Contact: www.iepbc.ca

The New Physiotherapists, UBC Grad Class of 2009

PABC was again honoured to be part of the MPT graduating class’s Convocation Reception in November where 40 young talents became members of our profession. To mark the occasion, PABC pinned each student with a name tag which included their name and title and the heart logo so that no matter where they travel, their patients and colleagues will know they are a physio and a member of PABC.

Gavin Stuart, Faculty of Medicine Dean, welcomes the graduates into the medical world.

Brenda Loveridge, Interim Head Department of Physical Therapy (2007-2009) and now the Special Advisor, Allied Health Professions, Faculty of Medicine, was given the honour of being chosen by the students to be the Guest Speaker. She admonished students to maintain during their career the 100% membership in PABC that the class had achieved in their UBC years, to always be a member of the “elite club of physiotherapy” through their professional association. ♦

EDUCATION FUNDING

PABC’s Ruth Byman Memorial Award

The Byman family has established an annual education award for a mid-career physiotherapist. This is in honour of their mother, Ruth Byman, a long-time PABC member. The award of $1000 is for tuition to a professional development program. Application Deadline is February 15th. See www.bcphysio.org. Members only site/PABC & You/Awards & Bursaries.

Francis & Associates Continuing Education Award, $1000

Francis & Associates recognizes the importance of continuing education in health care and would like to contribute and assist physiotherapists with an annual $1000 Continuing Education Award. Eligible continuing education activities would include: conferences (travel and registration), workshops, professional development courses, seminars, or graduate studies. Note: Students graduating in the current year are eligible to apply. Submission Deadline: May 15th. To find out more, email Education Awards generalinfo@francis-associates.com or visit www.francis-associates.com.

PABC Congress Funding

Each year, PABC helps fund a few members to attend CPA Congress. This year, Congress is in Newfoundland, so travel is particularly pricey. The funding is divided among winning applicants and preference is given to those who are presenting a paper or poster, or who are receiving an award. Details at www.bcphysio.org Members only site/PABC & You/Awards & Bursaries. Deadline is March 15th.

The award winners in the class were:

Catherine Chan: PABC Prize awarded to the student with the highest cumulative standing in all case-based integration course work.

Karen Waddington: PABC’s Amanda Reid and Rick Hansen Award for the student who has contributed to the promotion of the profession.

Meghan Curle: PABC Leadership Award for the student who has demonstrated leadership potential and ability and who has contributed to the profession in a unique and innovative way.

Jonathan Yiu: CPA Paediatric Award for the student who has demonstrated excellence in academic and clinical paediatrics.

Fawn Whiting: Dr. Brock Fahrni Prize in Physical Therapy for the student with the highest academic standing for the MPT degree. ♦

Jonathan Yui, Lawren DeMarchi and Aylee Fox flaunt their new PABC Physiotherapist name tags.

Rebecca Tunnacliffe pins Karen Waddington and Candice Bridge.
What Members are Doing

Martyna Chrzastowska’s West Point Grey Physiotherapy clinic won the Consumer Choice Award for 2009. Martyna received the award at the gala ceremony on December 13th at Vancouver’s Bayshore Hotel, and says, “Physiotherapy was included for the first time as a category chosen by consumers. The whole coverage of ceremony will be aired on Global TV early in February. I was presented with the Award by MP Andrew Saxton from North Vancouver. Because I am from Poland, there was also coverage in Vancouver’s Polish Newspaper TAKIE ZYCIE on January 2nd with this photo, shown below.”

Pam Tarves recently opened a new clinic in Nanaimo, Tarves Physiotherapy, at Ellen Place.

In the autumn, Keane Leung opened a new clinic on Kingsway in East Vancouver, Collingwood Physiotherapy & Wellness. Keane was an associate at Vita Wellness before going solo.

Aart van Gorkum has recently started up his own practice on Main Street in Vancouver, called Main Street Physiotherapy Clinic. After working at Treloar Physio clinic for eight years, he decided to go out on his own. Aart says, “Who knew how much work this was going to be. However, I am up and running and learning new things every day.” Along with starting his own clinic, he has recently been given Clinical Faculty status at UBC, where he teaches Surface Anatomy in the MPT program and assists in the Gross Anatomy lab. Marcella Paoletti will also be working at the clinic; she has a special interest in women’s health (and in Aart, who is her hubby). The clinic website is www.mainstreetphysio.ca.

Questions of Consent

When the PABC and CPTBC Joint Initiatives Committee conferred about the topic for our education at the Physiotherapy Practice Forum, the question of consent arose, and although there are many aspects of consent, we chose to focus on consent from the challenging patient.

Another consent matter that has been raised is whether PABC could provide a consent form template. Here is the complex answer to the simple question. Consent is a regulatory matter, and although having a “consent to treatment form” might be helpful, there are many mitigating factors that make the provision of a generic consent form impossible. The reason for consent to treat is to inform and protect the patient, and this consent must be the result of a conversation between the physiotherapist and the patient; written consent would serve to augment, not replace that critical conversation. Each patient is different and each conversation about consent to treat is different and cannot be covered by one generic form.

If you have a specific question about consent to treatment please contact Susan Paul BScPT, Practice Advisor, at the College. Susan can be reached at 604-730-9193 on Tuesdays and Thursdays.

PABC Film Critique

by Dr. Susan Harris

Law Abiding Citizen

Although Gerard Butler was riveting in his portrayal of a brilliant sociopath aimed at redressing a flawed sentence for one of the murderers of his wife and daughter, Jamie Foxx (as the Philadelphia prosecutor in the case) was not as strong as in previous acting performances. Unfortunately, the extreme violence and gore in this movie left this viewer wishing she had stayed home to watch a Joan Baez biopic on TV!

Rating: ★★★★★
Pain of myofascial origin received next to no mention during my entry-level degree. During my postgraduate studies, myofascial trigger points were either not discussed or they were summarily dismissed as a non-existent condition. As a result, for years I considered any myofascial abnormality I found as secondary to a primary articular dysfunction and was quite convinced that such minor issues would disappear once I had adequately dealt with the dysfunctional joint.

For me, myofascial trigger points only entered as a relevant construct into my clinical reasoning process after completing a course with Dr. Gunn in Vancouver. It was not that I agreed with the hypothesis of a radiculopathic etiology for all chronic myofascial pain presented there but I could not deny the beneficial effects I observed in my patients once I incorporated dry needling into my existing approach to patient management. I started considering myofascial trigger points as a possible primary or at least contributory dysfunction and took them into account in the differential diagnosis for a great variety of patients with orthopaedic and neurologic complaints.

However, unexpectedly the adoption of myofascial trigger points in my clinical reasoning processes also forced me to re-evaluate the evidence-based practice paradigm under which I then operated. It is hard to base your actions on evidence if, in many instances, all you have is expert opinion and a seemingly plausible theory extrapolated mainly from basic science evidence. But isn’t that the case for most things we physiotherapists do? My colleague, Jan Dommerholt, introduced me to the evidence-informed paradigm where research evidence does not dictate what I, as a clinician, do but where it merely informs me, as do other forms of evidence including clinical experience and expertise.

It is the same evidence-informed paradigm that guided Jan and I when we were putting together this new textbook on myofascial trigger points. This book does not try to answer the many questions surrounding myofascial pain. In fact, often it will provide new and unexpected questions. Not meant as a comprehensive or uncritical resource on all things myofascial, with its combination of research, clinical experience and expertise, suggestions relevant to everyday clinical practice, critical analysis, and the presentation of hypotheses, this book serves simply as an introduction for those clinicians willing to look beyond the joint-centered paradigm that is still so central in many schools of thought within orthopaedic manual therapy and, thereby, perhaps provide some suggestions for managing patient problems not adequately addressed under that paradigm.

I invite you to check out the book and some sample full-text material (under additional resources) at: [http://www.jbpub.com/catalog/9780763779740/](http://www.jbpub.com/catalog/9780763779740/). And while you are there, maybe also check out the other books in the series “Contemporary Issues in Physical Therapy and Rehabilitation Medicine” for which I serve as the Series Editor. Some informative texts are already available on orthopaedic manual therapy diagnosis, wellness, cervicogenic and tension-type headache, and clinical prediction rules with books scheduled this year on migraine headache, extremity manipulation, chronic pelvic pain, and physiotherapy for performing artists. ♦
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Physiotherapy Practice Forum
PABC Call for Posters
PABC is pleased to invite your participation in the 1st Annual Clinical and Scientific Poster Session at the 2010 Physiotherapy Practice Forum
Details on page 13 of the newsletter or contact PABC Board Director, Lois Lochhead, lois.lochhead@shaw.ca

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Directions in Physiotherapy

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Winter 2010  Promoting Excellence in Physiotherapy

PABC Professional Development 2010

Evening Lecture/Video & Audiocast Series – Spring

Your Basic Skills Refreshed

1. March 31: Hot & Swollen: Ice, US, Laser or IF with Alison Hoens MSc, BScPT

Physiotherapists are faced with many choices of potential interventions for the management of inflammation, edema or swelling. Although these three stages each have unique characteristics they are often viewed synonymously and treated similarly; however, recent evidence suggests that different therapeutic management strategies may be preferable. Physiotherapists will learn a decision-making framework to optimize treatment strategies for each stage.

2. April 27: Tendonopathy: More than just the Achilles with Alex Scott PhD, BScPT

This lecture will review the problem of tendonopathy, reveal new insights into injury mechanisms, and discuss current and emerging physiotherapy treatments and strategies for injury prevention. Alex is a post-doctoral fellow at UBC whose research is focused on understanding the molecular mechanisms of tendon overuse injuries (tendinopathy).

Lectures/Videocast Details

Location/time: VGH Main Auditorium, 855 West 12th Ave. 7:00 - 8:30 pm
Videoscasts: distributed to registrants one week following the live lecture
Fees: PABC members $40 ($5 for students); future members: $60
Videocast “group” rate per site: PABC members $60; future members $120

Weekend Courses

Spring Course

A Comprehensive Approach to the Science, Theory and Clinical Rationale for Lumbar Assessment and Interventions with Ola Grimsby, PT, MNFF, MNSMT
May 15 & 16, 2010 9:00 am – 5:00 pm UBC
Fee: $525 members; $700 future members

The renowned manual therapist and educator, Ola Grimsby, presents leading research on manual therapy, and provides participants with the skill to define, discuss and evaluate the evidence. He will teach techniques of mobilization, oscillation, high velocity short amplitude manipulation, and individually dosed tissue specific exercises related to mobility and functional stability, as well as how tissues respond differently to nutritional and bio-mechanical stimuli.

Fall Course

Getting Answers to your Joint Replacement Questions with Drs. Bas Masri and Bob Hawkins, PTs Bruce Clark and Cam Bennett
October 16, 2010 8:00 am – 4:30 pm UBC
Join orthopaedic surgeons Dr. Bas Masri and Dr. Bob Hawkins, along with physiotherapists Bruce Clark and Cam Bennett, for a one-day update on joint replacement techniques and rehabilitation. Come and see what the experts have to say about your patients who have had hip, knee or shoulder arthroplasty. Course details and registration information will be available this Spring.

To register for the 2010 Courses or Lecture/Videocast or Audiocast Series, simply:
1. go to www.bcphysio.org and click Courses/Events on the top right
2. read the descriptions; scroll down to “To Register …. Click Here”
3. click “sign up” on the course or lecture you’re interested in

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