Three-dimensional Gait Analysis of Runners

by JR Justesen, BScPT, FCAMT, CGIMS

Running as an exercise form has a number of health benefits, but there is a darker side as well. We have been researching the dark side.

Depending on the source, 27-70% of runners of various skill sets may become injured in the next year. Working in partnership with Dr. Reed Ferber and the University of Calgary’s Kinesiology department, we are attempting to better understand the biomechanics of running, whether there are consistent biomechanical findings associated with specific running injuries, and how the mechanics of gait may relate to strength, flexibility and alignment. Subjects are runners with and without injury. This information will help us to better treat and prevent running injuries. We provide a biomechanical service to clients while providing quality running injury data to an ever-growing database.

We collect four sets of data: three-dimensional gait analysis, lower extremity strength measures, lower body flexibility measures and lower body alignment.

Three-dimensional motion capture is performed with the Vicon Bonita 3 Camera System. This well-tested system, used in the health sciences, engineering and entertainment industries, is really the cornerstone of accurate and reliable 3-D data collection. Reflective markers are placed over the pelvis, thighs, shanks and shoes. Joint centres are first identified at the hips, knees and ankles for a two-dimensional reference point. The joint centre markers are then removed and the Vicon system tracks only the movement of the shells in all three planes. The subject is allowed a warm-up period of between 2-10 minutes before motion analysis. The system is calibrated for each subject and measurement error is less than 1 mm in any given plane.

We look at the following gait variables for left-to-right and interstride differences:

1. Peak pronation
2. Peak pronation velocity
3. Time to peak pronation
4. Peak tibial internal rotation
5. Tibial internal rotation velocity
6. Peak knee abduction (inward collapse)
7. Peak knee abduction velocity
8. Peak knee internal rotation
9. Peak knee flexion
10. Peak hip adduction
11. Peak hip internal rotation
12. Peak hip extension
13. Peak pelvic drop
14. Heel whip
15. Foot progression angle
16. Stride width
17. Stride rate

Strength measures are taken with a handheld digital dynamometer (Lafayette Instruments). Range of Motion testing is performed with a standard goniometer and a digital angle inclinometer. Testing methods are standardized to those of Kendall and McCreary.

continued on page 4
BC Physios are Unique!
Jump on the Brand-wagon to Make our Message Ubiquitous

by Rebecca Tunnacliffe and Scott Brolin

When asked the value of PABC membership, you told us that high on your list is promoting the profession.

We have a new promotional campaign that uniquely positions you and distills into one tagline the reason you got into physiotherapy: to Keep British Columbians Moving for Life.

In 2011, PABC’s Board of Directors saw an opportunity to create a new image of the BC physiotherapist. We recognized that British Columbians are unique in our love of outdoor life year round. We take pride in getting out there and being active. A 2011 study also cited BC as the most physically active of all provinces. To keep active, this province depends on our profession. Our profession also has the unique attribute of being the most physically active of any health profession.

Following the axiom “if you’ve got it, flaunt it,” we are positioning you as the most able to help BC keep active because we are the active profession — we know the injuries, treatments and preventions better than anyone because BC physiotherapists are the most active health profession in Canada.

In 2011, we launched a new TV ad, website, traditional and social media campaigns, as well as a new logo that captures the sense of the active BC lifestyle that you help maintain. Now we have tools for you too! We are launching the Brand Champions program to amplify our work to heighten public recognition of physiotherapy and the uniqueness of BC physiotherapists. You are PABC’s brand Champions.

This new program is designed to extend our promotions by reaching every household in the province through your use of our newly created promotional tools. With each of our 2100 members as Brand Champions, think how many British Columbians we can keep moving for life!

Help PABC let BC know that physiotherapists not only keep them moving for life, but that we hold the unique and envious position of being the most active health care provider in Canada!

In hospitals, clinics and communities, you now have easy monthly tools to let everyone in your sphere become aware of how you keep people moving, as well how you model BC’s active lifestyle. Let our tagline, Keeping British Columbians Moving for Life, open conversations and be a phrase that summarizes what you do.

In the Members Only site, www.bcphysio.org/member, you will find the tools you need to become a Brand Champion and promote the message that BC’s physiotherapists keep British Columbians moving for life.

Brand-Wagon Tools for you to amplify the BC Physiotherapist brand:

1. Introduction to this month’s program – building healthy hearts
   • an introduction for you to begin the conversation about how we help to build healthy hearts.

2. How can you share your knowledge about building healthy hearts?
   • some ideas on where you can speak to groups that would benefit from your knowledge and expertise on building healthy hearts.

3. Twitter – tweet those tips, stories, pictures and videos!
   • An easy how-to-guide to set up your own Twitter account and use Twitpic to share photos;
   • The Physio-4 tips shrunk down to “tweet” size (140 characters or less) including a link to the PABC website’s Physio-4 page;
   • Tweet out stories/photos/videos from your practice on how you are keeping British Columbians (your patients) moving for life;
   • Tweet stories/photos/videos on how you are a role model for an active lifestyle – bike, swim, ski, run, garden, etc.

4. Facebook – share those tips, stories, pictures and videos!
   • An easy how-to-guide to set up a Facebook page for your practice;
   • The Physio-4 tips for sharing on Facebook including a link to the PABC microsite www.movingforlife.ca Physio-4 page;
   • Share stories/photos/videos from your practice on how you are keeping British Columbians (your patients) moving for life;
   • Share stories/photos/videos on how you are a role model for an active lifestyle – bike, swim, ski, run, garden, etc;
   • Share a video or photos of you or a colleague demonstrating the Physio-4 tips.
5. Physio-4 Tips Sheet
   • For you to customize with your workplace name and contact information.

6. Monthly Media Release
   • For you to personalize so the quotes are attributed to you or another physio in your practice and to include your workplace name and contact information;
   • Media contacts listed by region so you can distribute the release to contacts in your area

7. Ask for Physician Referrals
   • Establish monthly contact with referring physicians and hospital colleagues by providing them with the Physio-4 for that month and relating a story about how you are keeping British Columbians moving for life.

Quarterly Contest — Patient Stories on Building Healthy Hearts

Do you have a success story on how you have helped a patient build a healthy heart? Tell us about it. One winner will be selected each quarter and receive feature billing on the movingforlife.ca website and in the Directions Newsletter, PABC swag, and a free PABC webinar, plus bragging rights (priceless!). Please include:

• your name and workplace
• your diagnosis of the condition
• your treatment approach
• the outcome
• patient testimonial (if possible)
• any notable physician involvement
• photo of you and/or patient

We look forward to seeing how you are keeping British Columbians moving for life. The winner will be announced in our next Directions newsletter.

Member Kudos for PABC’s Fall Town Hall Meetings

If you missed the Town Hall, you can see/hear the presentations now posted at www.bcphysio.org/members.

PABC K-Team is an awesome resource. Enables me to do a significant amount of research and independent study.

Thank you for bringing the incredible developments to our attention. I will make the time to review the website and utilize the information.

Excellent — I think it makes all the difference to engage members in the flesh — thank you so much for your time. Members $ well spent.

Love the new logo & branding, great idea! Great info on all the social media outlets. I will be sure to check out the new website and microsite.

It was great to meet people and re-discover all of the things PABC does for its members.

All very exciting — I am familiar with PABC K-Team, Social Media & Branding and have been browsing our PABC Members Site more often this year than previous years & of course through eblasts. Now I just need to use them more often and become more familiar with how to use them (especially Social Media)

I took more time today to go through our PABC website and the Facebook site and I am so impressed and proud to be a PABC member.

Buddy Lunch

The second year MPT students threw a party for the incoming class in the fall, and PABC Student Director Michelle Soh with the help of CPA NSA Student rep Kamira Peters made sure PABC was front and centre by highlighting the benefits and also circulating the PABC-provided cookies.

L-R: Lisa Cornish, Kamira Peters, Michelle Soh
Three-dimensional Gait Analysis of Runners...continued from cover page

We look at the following strength and flexibility variables:
1. Hip abduction strength
2. Hip external rotation strength
3. Hip internal rotation strength
4. Hip flexor strength
5. Hamstring strength
6. Ankle inversion strength
7. Ankle eversion strength
8. First MTP joint extension
9. Gastrocnemius and soleus flexibility
10. Hamstring flexibility
11. Quadriceps flexibility
12. Hip internal rotation flexibility
13. Hip external rotation flexibility
14. Hip flexor flexibility
15. IT Band (Ober Test)

Finally we take the following measures of alignment:
1. Leg length
2. Q-Angle
3. Rearfoot eversion
4. Midfoot position
5. Arch Index (Seated vs weight bearing dorsum height of the arch)
6. Standing rearfoot tibial angle
7. Standing rearfoot eversion
8. Standing foot posture (supinated/neutral/pronated)

There are some challenges to this type of gait analysis. Treadmill jogging is not an exact reproduction of overground running and we do not fully understand how the body adapts to a particular treadmill situation. A small percentage of subjects do not receive the analysis simply because they are too uncomfortable jogging on the treadmill. Although the biomechanics of treadmill jogging have been shown to be similar to overground jogging, one study found that subjects consistently land with a flatter foot on the treadmill. Incidentally, we test runners on the level but some runners ask whether it is better to test at a 1% grade. This grade was found to most closely reproduce energy consumption but was never tested in relation to the biomechanics of overground running.

We frequently see biomechanical patterns that appear to have logical explanations based on our findings of strength, flexibility and alignment. For example, weak hip external rotators can be associated with an increase in hip internal rotation and may continue down the entire kinetic chain. There are a number of similar examples.

We have written a guide of common findings based on the 17 gait variables mentioned above, and have made this available to PABC members at www.bcphysio.org/members. The body, however, is a complex and adaptive system; thus these findings will not guarantee better gait analysis or interpretation but are intended rather to assist the clinician in gait analysis.

The scope of this article does not allow for a greater level of detail but you are welcome to email me for a copy at jrr@parkwayphysiotherapy.ca.

JR Justesen is a UBC physiotherapy graduate and co-owner of Parkway Physiotherapy in Victoria. He and wife Renee of 25 years have three sons and have begun volunteering weekly with street youth because they “hope to make a positive dent in the universe.” JR credits physiotherapy with giving him “near opportunities” including working in professional soccer with the son of former Libyan leader Moammar Gadhafi.

Two new Physio PhDs
Chuck Ratzlaff and Rick Celebrini, long-time friends and clinic colleagues, graduated together with their PhD in November. Chuck had the added honour of having his father, UBC Professor Emeritus, on stage to see him bestowed with his new degree. An erudite family, Chuck’s brother crossed the same stage two days earlier to get his Masters degree.

Bobath Interest Group: Connect, Learn, and Share!
by Corinna Ng, MPT

When I graduated four years ago from the UBC physiotherapy program, I knew I wanted to pursue my interest in neurological rehabilitation. This interest led me to take several post-graduate neurological-related courses, one of which involved the Bobath Concept, a problem-solving approach to the assessment and treatment of individuals with disturbances of function, movement, and postural control due to a lesion of the central nervous system. Through these courses, I learned about the Bobath Interest Group (BIG) which is a subgroup of CPA’s Neuroscience Division (NSD).

BIG was formed by a small and dedicated group of therapists in 2007. The BIG executive committee has been working hard to grow and expand the membership each year. One of the main goals of this group is to develop a peer network between clinicians across Canada to facilitate discussion on their interest and practice using the Bobath Concept. BIG has developed a chatboard website on Proboards where BIG members can post questions, articles, and videos for others to view and discuss.

Another goal of this group is to help clinicians interested in the Bobath Concept to attend Canadian Bobath Instructors Association (CBIA) courses through the development of a bursary fund for eligible candidates. BIG is now offering bursaries to BIG members that plan to attend CBIA courses.

If you are interested in learning more about the Bobath Concept and connecting with others interested in this area, please go to our website: http://bobathcanada.com/bobath_interest_group/index.php. You can sign up for our free membership and help us expand our peer network with your ideas. We are always eager to have new members on board!
About 12 years ago, I embarked on an adventure in diagnostic ultrasound that has been one of the most rewarding experiences of my professional physiotherapy career. Although it was a new concept when I started, MSK Ultrasound (US) is now widely accepted to be more accurate than standard clinical examination at detecting joint effusions and synovitis at a variety of anatomical sites. Current research has also shown that US and MRI exhibit greater sensitivity for detection of erosive progression than x-ray.

My Journey to Certification in Ultrasound

My adventure with diagnostic ultrasound began in late 1990. I read about and listened to lectures by Paul Hodges and Judy Hides on stability training and the use of Rehabilitative Ultrasound Imaging in physiotherapy practice. I initiated contact with Jackie Whittaker, a pioneer in ultrasound use for physiotherapy, but did not follow through simply because the cost of an ultrasound machine was too high.

In 2007, The Mary Pack Arthritis Centre (MPAC) where I work purchased a diagnostic ultrasound system from a local company called Ultrasonix. The MPAC physiotherapy staff received some initial training in Rehabilitative Ultrasound from Jackie Whittaker. We were excited to be able to practice our skills and give our patients feedback with static and dynamic imaging. Over the next couple of years I worked with Greig Hyland at Ultrasonix to learn some scanning techniques, and began scanning my back patients with core muscle impairments. At that time, I was disappointed that I could not use this technology for my inflammatory patients.

Big Changes Started in 2009

The situation started to change in 2009 when local leaders in the rheumatology field — Dr. Wade and Dr. Collins with help from Abbott Lab — started to work with world experts in MSK Ultrasound and Rheumatology. I was invited to participate in workshops with Professor Grassi from Italy and with Dr. Wells from Duke University.

During these workshops, I learned how to scan rheumatology patients for disease activity especially looking at synovitis, tenosynovitis, and erosions in the small joints of the hands and feet. The next big step in my ultrasound education was at the Canadian Rheumatology Conference in Quebec where I met the Canadian leaders and future funders of the Canadian Rheumatology Ultrasound Society (CRUS), Dr. M. Larche, Dr. A. Bruns and Dr. J. Roth. I have kept in touch with the group and was invited to participate in a certification study for Rheumatologists at McMaster University.

Over the next five months, I travelled to Hamilton for intense MSK Diagnostic Ultrasound training. To demonstrate the skills I was learning, I had to submit 20 images online every week for evaluation and feedback. Finally, in March 2011, I had a three-hour theoretical exam and practical exam on arthritis patients. I received my certification in MSK Diagnostic Ultrasound with CRUS in June 2011.

I am now trained and certified for MSKUS and have been using Diagnostic and Rehabilitative Ultrasound regularly on my arthritis and orthopaedic patients since earlier this year. In Rheumatoid Arthritis patients, I evaluate joints for sub-clinical synovitis, bone erosions and tendon pathology. The Power Doppler screening on the ultrasound system allows me to detect inflammatory activity.

I believe physiotherapists in this province are in a unique position to be champions in the clinical use of Diagnostic Ultrasound with support from Ultrasonix, a local manufacturer of ultrasound equipment. The company has an education facility in Richmond that would allow for hands-on training. If you are interested in learning more about this opportunity, please contact me at bentallphysiotherapy@gmail.com.

Acknowledgements

I have many people to thank for my success in becoming certified in the use of ultrasound for MSK. I would not have been able to do it without the support and encouragement of many colleagues including the director of the Arthritis Program Bev Hills, my physiotherapy manager Catherine McAuley and the leaders of CRUS. I must also thank Greig Hyland and Linda Pendziwol from Ultrasonix for their ongoing support during my certification and for their encouragement and vision to expand the clinical use of MSK Ultrasound into physiotherapy practice.

Jacek Kobza owns Bentall Physiotherapy Clinic with his wife Mariola and has been working at the Mary Pack Arthritis Centre for the last 20 years. He not only provides physiotherapy treatment for arthritis patients but also actively participates in the International Arthritis Conferences as a speaker in the area of arthritis back pain and advanced post-operative treatment in hip and knee replacements.
Physiotherapy “eTools” for Public Practice: Trying to Keep Up

by Chiara Singh, BScPT, Public Practice Advisory Committee Chair

In recent articles, I have focused on some serious issues in public practice (hospital overcrowding, collective agreement and specialization). For this issue, I wanted to take a more lighthearted foray into the relative unknown (for me) and introduce some tools that I am just discovering. Even though at my age I should be at least a little computer savvy, I am way behind many of my age group peers in this regard. I just recently updated my phone and entered the world of “apps”. This update, some reading and some references made at Congress in Whistler got me thinking about the possibility of using this phone as a practice tool.

No matter what area of public practice you work in these days, there seems to be an overarching theme of too little time and a lack of resources. In addition, a lot of physiotherapists in public practice need to physically carry all their tools while going from room to room or house to house. Your cell phone has the potential to assist you in your day-to-day practice and has the added convenience of being very portable. Here are some examples:

1. **Simple Goniometer.** To use this tool, you simply place your phone next to the joint being measured in line with the axis and use your finger to drag the arms to match the bony prominences. There are also more complex goniometers for the knee, forearm pronation/supination and a scoliometer that use accelerometers to measure angles. You can find out more about these tools here: http://www.ockendon.net/.

2. **Metronome.** I first heard of using the metronome app at a session at Congress this year talking about pacing patients as they walk in time to a metronome to prescribe intensity. You also can use the metronome while your patient is walking on a treadmill at a certain speed to determine step length.

3. **Drug references:** **Epocrates** has reliable drug, disease and diagnostic information. It includes a pill ID that can be used to identify medication by physical characteristics.

4. **Exercise:** **Physiotherapy Exercises** allows you to search for exercises by condition, exercise type, equipment and age. **Motion doctor** is one app that can be used for teaching exercises. **My therapy exercise** is endorsed by the APTA and can be used by patients. There are also some condition-specific apps like **Parkinson Home Exercises** that includes videos for home exercises and a metronome with vibration.

There are also apps for trigger points, timers, BMI calculations, anatomy, respiratory exercises, games to engage children, medical translation (with audio) for several languages and a lot more that I am missing. The UBC Physiotherapy students are also using an app to track the types of patients seen on placement. To access any of these apps, you just need to go to the app store (online) for your specific device. You can do this by typing “app store” and the name of your device (e.g. iphone, android) into a search engine.

More and more, I am seeing doctors and pharmacists using these devices in busy hospital settings. Although all this technology can be overwhelming, and there are many details to think about when using these tools in public practice (infection control, access, confidentiality), I believe we need to expand our practice and be open to the benefits of these resources.

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**Living Well: Helping Colleagues Help Patients**

by Michelle Edmison, BScPT, FCAMT, CGIMS, CAFCI

Do you dream of having your patient exercises organized so you never have to draw a stick man again? Do you dream of having useful resources so it is easy to share information with patients? I did, and I decided creating a website with all of this information would be my maternity leave project.

There were some challenges. I knew nothing about website design. I just had a baby, so not the ideal time to slap on spandex, pose for exercises and then voluntarily post pictures of them on the internet. Maternity leave didn’t actually involve a lot of spare time for projects.

There were also some pleasant surprises. I bought a Mac computer and joined Go Daddy — they made creating a website easy and fun. We quickly discovered which camera angles were flattering for a post baby body and which were not. But the most pleasant surprise was that I saw a whole new side of my profession. When I began gathering the information to share with patients, I realized there was a limitless range of topics. Physiotherapists
Another Successful P.A.R.A.D.E.

by Andrea Chan, BScPT and Janet Lundie, BMR-PT

The Fraser Health Authority (FHA) held its third annual P.A.R.A.D.E. (Physiotherapist & Rehabilitation Assistant Day of Education) on November 16th at Surrey’s Eaglequest Coyote Creek. Two hundred PTs and RAs representing acute, rehab, outpatient, community, and long term care from across the region came together for a day of networking and education.

Janet Lundie, the P.A.R.A.D.E. work team shared-chair, opened the event and welcomed all the attendees, sponsors, and community partners. PABC members were prominent as award recipients and presenters (as below, unless otherwise noted).

Two physiotherapy recipients of Fraser Health’s 2011 Above and Beyond award were recognized: Chiara Singh and Ruth Pollock. This was followed by academic updates by PABC members Sue Murphy for UBC’s PT Masters program and Tracy Dignum for the rehabilitation assistant program at Capilano College; Carmen Kimoto and Vancouver Community College also provided an RA update.

Four education sessions were offered during the event:

• Oncology (Dr. Kristin Campbell and Chiara Singh) presented current best practice for exercise rehabilitation and an update on FHA’s post-surgical research project.
• The F.A.M.E. and G.R.A.S.P. programs (Dr. Janice Eng) demonstrated the importance of ongoing exercise and community partnerships for clients post stroke.
• Physiotherapy from both sides (Tori Feige and Rob Gosse) shared the experiences of both wheelchair mobile speakers as a physiotherapy student and rehabilitation assistant.
• Safe Mobilization (Karen da Silva with non-members Frank Chung & May Urbina) outlined clinical scenarios to highlight PABC’s evidence-based clinical decision-making tool when mobilizing after critical illness.

This year’s P.A.R.A.D.E. was a huge success, thanks to the enthusiasm and interest of its 200 attendees for continuing education and practice improvement. PABC members Andrea Chan, Karen daSilva, Jane Erskine, Sam Deakin, Teresa Francis, and Janet Lundie were joined by FHA physiotherapists Cynthia Riddell, Lily Luong, and Michelle Peterson, and RA Marleen Greeve in the dedicated shared work team. 🏋️‍♂️

Congratulations to Neil Pearson who has been given the prestigious Education Award from the Canadian Pain Society. The award will be granted at the May 25 annual CPS conference where Neil will also be presenting ‘Building New Treatment Paradigms: Beyond Gates, Fear-Avoidance, and Distraction’.

Michelle Edmison, Physiotherapist at Canopy Integrated Health in North Vancouver, is the new mother of Joshua Brian Bain born December 2010. 🎉

Michelle Edmison conducting a postural retraining so that this patient’s chronic tight neck muscles will go away and stay away.

The World Health Organization defines health as “a state of complete physical, mental and social well-being...” As physiotherapists I believe we are uniquely positioned to help people achieve this total health. Our patients may come to us for a physical injury but they often leave feeling better and also living better lives.

At the end of my maternity leave I launched physiome.ca, a website for people to learn what they can do to take control of their own health to get well, stay well and live well. It includes: exercises, common conditions & injuries, injury recovery & prevention, perinatal health, motivation mindfulness, nutrition, life balance, recent research trends in sport, health & wellness, and much more. Check it out and don’t forget the potential of our profession!

Michelle Edmison, Physiotherapist at Canopy Integrated Health in North Vancouver, is the new mother of Joshua Brian Bain born December 2010. 🎉

Back row, L-R: Lily Luong, Janet Lundie, Teresa Francis, Andrea Chan, Karen daSilva

Front row, L-R: Michelle Peterson, Jane Erskine, Cynthia Riddell, Sam Deakin, Marleen Greeve
Grow your Practice with the Ultimate Differentiator – Customer Service

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

In past articles, we on PABC’s Business Affairs Committee have tried to identify the key characteristics that make a physiotherapy clinic financially successful. We pored over the results of the Cost of Business Survey (COBS) over the last number of years and pulled out variables that were consistent with a profitable business. The theory was that if each clinic were to adopt these variables, financial success would follow.

We questioned, “What if the key components to success are not measured in COBS?”

I also have had many conversations with physiotherapists about what they think brings patients in to see them. Most of the time, the response is that “my patients get better”. That’s great, but is that really what drives patients to come back, and to tell their friends? I recall reading a therapist’s file where the assessment looked to be correct on paper and the initial response to treatment was positive, but the patient did not return for that ever-important follow up to truly manage the condition. Why did the patient not show up for the next appointment?

In talking to patients and asking what they want from their therapist, I hear “I want them to fix me up” or “I want to get rid of the pain”. When I ask the patients how the therapist will do that, they say “they will listen to me and understand what the problem is.”

How then does the expectation to ‘feel heard’ influence the patient experience?

This is where I believe the great differentiator lives. It lives in the creation of an atmosphere where communication and clinic culture manage both the rational and emotional expectations of their patients. Mr. Qaalfa Dibeehi, (Global Customer Experience Management Organization, Director of Thought Leadership) highlights a model in his website that explains the role that emotional and rational expectation management have on improving the customer experience. I am confident that if you give it the few minutes it takes, you will be glad you did. http://goo.gl/c59lH.

Applying Mr. Dibeehi’s model to a physiotherapy clinic, one can quickly see the impact of not meeting either the rational or emotional expectations of a patient. This might be the result of taking a check-box history with closed-ended questions and prescribing an ineffective treatment. The patient will neither feel heard nor will their pain improve. This is referred to as the ‘Dead Zone’. Clinics will not survive in this zone.

Managing the pain complaint through an appropriate assessment and treatment plan manages the rational expectation that the patient will have for the physiotherapy session. However, it does not manage the emotional expectation. If the patient isn’t given time to explain their needs (eg. how the injury is impacting them, how they wonder about how it may be something more serious, etc.) and the presentation acknowledged, the emotional expectations for the visit will likely not be met. This is referred to as the ‘Commoditization Zone’. Anyone with the appropriate training in physical therapy can offer this. However, a clinic in this zone will risk losing patients if another clinic opens down the street.

The therapist that offers up the time and addresses all the emotional expectations of the patient but neglects the appropriate management of the underlying condition is operating in the ‘Danger Zone’.

The target zone where both rational and emotional expectations are addressed is the ‘High Performance Zone’. The physiotherapist has the capability to identify the patient needs and spend the appropriate time and consultation to address each need effectively. You may recognize this therapist as the one who has more personal requests for them at the front desk, and fewer cancellations or ‘no shows’.

So, we all have done numerous courses to improve our physiotherapy skills — how many of us have worked just as hard on managing the emotional expectations of our patients? How do we go about doing this? What questions do we ask? What are signs that we are missing this piece during our assessment?

Many believe that the area of Emotional Intelligence (EI) holds the information that is a key to learning how to be an effective
listener. For example, the Workplace Strategies for Mental Health www.gwlcentreformentalhealth.com website has uploaded material on ‘Building Reflective Listening Skills’ that can help therapists identify easy strategies to use to be better listeners and to identify the emotional expectations of their patients. This material and other material on the site, including a skills assessment, are free and relate directly to being a better communicator.

Are you treating only half the patient? Our environment is competitive. Kinesiologists, chiropractors and other health care workers are attempting to mimic physical therapy. Managing both the rational and emotional patient expectations will help drive your practice into the ‘High Performance Zone’!

As I indicated in my two previous articles, insurance companies expect that we will provide more than just treatment of an injury. I referred to it as macaroni and cheese: the insurer does not wish their macaroni without cheese. At present, physiotherapists are not paid to prepare Return to Work (RTW) plans, but insurance companies such as WSBC, ICBC and general insurance may choose to request these of us in the future.

Planning RTW is a fairly straightforward process:

1. You have established what the client does at work, either by having them fill out a job demands form when they come for one of their early visits or by getting the job demands form filled out by the employer.
2. You have monitored the functional progress of the client using simple tools such as lifting and carrying assessments etc.
3. When establishing the RTW Plan, make sure that you have the proper consent to contact the employer and discuss the return to work.
4. Outline which tasks in the individual’s job you feel they can return to, and for how long they should be at work in their early shifts. Many companies have lighter duties to which a client can return in the early stages. The RTW plan itself is simple: on a calendar, write in for Week One which tasks the individual should not perform. Some examples are no lifting more than 20 lbs, no lifting overhead, allowing the client to take extra breaks to stretch or use ice.
5. Next is the process of marrying the return to work with your client’s recovery. If the client is to be treated as an extra worker this should always be cleared by the Case Manager.
6. Put the plan in writing and get approval from the client’s physician and case manager and then circulate the plan to the employer, physician and case worker.

Many physiotherapists are not comfortable contacting employers to discuss RTW; this can, however, be an excellent marketing tool. A happy employer will mention that you provided this service and therefore you get return business.

In Summary:

1. Ensure you have consent to contact the employer.
2. Develop a plan which will assist your client to return to work in a safe and sustainable manner.
3. Ensure the physician supports your plan.
4. Ensure the case manager supports your plan.
5. Follow the worker during their return to work and monitor their progress. In most cases they will continue to attend outside of working hours which makes monitoring really easy.

As I indicated at the outset of this article, the major insurance companies have not at present reached agreement about paying physiotherapists for RTW planning. You might, however, find it useful to work with some clients and go through the process as a learning tool. This is a service we can provide should the case worker request it and be willing to compensate us for it.

Scotty McVicar recently retired from his long-time ownership of Oceanside Physiotherapy & Work Conditioning Centre in Parksville. He is now semi-retired from physiotherapy practice, assisting north Vancouver Island clinics with locum services.
Facial Treatment by Skype
by Susan Rankin, BScPT, MHSc

Just as 2011 was ending I took, what is for me, a rather large technological step. I had started to see facial palsy patients again and several had come to see me from Victoria. Getting to Canopy Integrated Health in North Vancouver is quite a commitment for them. So when one of my patients requested that we try our follow-up visit by Skype, I breezily responded, “sure why don’t we try it!”

Now I should explain that I have been dragged kicking and screaming into the technological era! I was one of the last people to have a cell phone. Although I was introduced to computers in the 1980s by my technologically savvy husband, my main use was to create Word documents. I have always preferred pen and paper over email, and phone calls to texting. Fortunately, between two grown children and my husband, I have been made aware of what’s available, including Skype.

December 30 arrived. I tested my Skype connections and called my client at the appointed hour. It took about seven or eight minutes to get the lighting right so I could see her face well. There was no time lag and I could see all her minute facial expressions. My client also stated that she could easily see me modeling movements for her. Just as important was the feeling of connection between us and the ability to pick up on subtle, personal things that could be affecting performance. I had feared that this would be missing if we weren’t in the same room. It was great! We agreed to Skype for our next appointment.

Although this technology wouldn’t work for most physical therapies, for facial retraining it is a great option for those challenged by traveling from afar. It would not be suitable to do an initial appointment by Skype as there is a physical component to the assessment. However, I will invite previously seen patients to make follow-up appointments by Skype as needed and have physical appointments at intervals. Who knows, maybe I’ll embrace twitter, etc.

Susan Rankin recently started a new practice in North Vancouver with Cheryl Leia, Hygeia Integrated Health hygeiahealth.ca. They specialize in treating facial nerve damage, vestibular problems, pre/post partum incontinence, osteoporosis and fall prevention.

ICBC Update
by Marj Belot B.Sc.PT, M.Sc, FCAMPT, CAFCI, PABC’s ICBC Liaison

The dust has begun to settle at ICBC. We now have three contact people that PABC communicates with and with whom we are planning to meet regularly in 2012: Linda Calbick, Claims Services Manager; Sheryl Kozyniak, Claims Stakeholder Services Manager; and Rob Wilson, Claims Services Director.

ICBC is updating their website to improve visibility of and search for physiotherapists for their customers. They are also developing two e-forms to reduce unnecessary phone calls between physiotherapists and adjusters and to improve communication. One form will be a brief one with treatment areas and a very brief treatment plan (no fee) and one will be a longer form to report progress in place of the CL20 (fee charged). PABC has offered to work with ICBC, including educating adjusters and our members, to make the implementation process of the forms as smooth as possible.

A recurrent and distressing problem in 2011 was the mistaken belief among adjusters that physiotherapists are not qualified to provide supervised exercise programs, and that kinesiologists are more qualified to do so. We are working with ICBC to address this issue; most likely a component will be added to the training of bodily injury adjusters so they are better informed as to the scope and qualifications of physiotherapists. We have made inroads in adjusters changing their language from “active program” to “supervised exercise program” and dropping reference to “passive physio.”

Adjusters have also been approving a limit of $50 for supervised gym programs. Linda Calbick has determined that this was because adjusters assumed that any gym program was delivered by kinesiologists, and they therefore were prepared to pay only kin rates. Be sure to stipulate that your supervised gym program is physiotherapist administered in order to be paid at the physio rate.

And a piece of good news: the limit of physiotherapy treatments has been increased from 12 to 20. In ICBC’s new focus on excellent customer service, they wish to reduce adjuster micro-management; they recognize that 80% of injury claims are non-complex and that the physio can be depended upon for expertise in managing without adjuster contact. For the 20% that are not straight-forward, we have the CL20. For the customers that won’t return to work within 20 visits, you will need to contact the adjuster to discuss your strategy for recovery. So, no GP and no adjuster for 20 visits. Of course we expect our average number of visits to remain the same – this extension of limits is for your convenience and is not intended to establish a higher norm for recovery.

ICBC has not addressed fees in 2011 but this remains a high priority for PABC. We will ensure that ICBC is aware of the importance of this issue to our members and work to facilitate progress.

We encourage patience; however, please do not hesitate to communicate your concerns, comments or questions to me at belotphysiotherapy@gmail.com or to PABC at info@bcphysio.org. Many commonly asked questions are answered on the PABC website.

Marj Belot practices at West 4th Physiotherapy Clinic in Vancouver and is a registered instructor with the Orthopaedic Division of the CPA.
Physiotherapy: It really does keep you moving for life!

by Anne Harris, MSc(PT)

Like many student physiotherapists, I went into my first year of school confident that I would work in private orthopedics physiotherapy. Having participated in competitive sports since high school, I was exposed to the world of physiotherapy at an early age. However, my experience with sports physiotherapy gave me a limited concept of other practice areas. I remember being perplexed when I was required to buy a stethoscope for my first year of school; I was confident this piece of ‘medical’ equipment would collect dust on my shelf in the years to come.

In fact, my journey has taken me far from what I had envisioned, and has put my stethoscope to use on a daily basis! Through student placements, casual work, and a rotating position in acute care at a general hospital, I developed an interest and passion for neurology. I have been fortunate to be involved in this field for the past few years in a variety of public practice positions, including acute spine and acquired brain injury rehabilitation. I also trained as a Hatha yoga instructor and have recently been integrating this into my work with people with neurological conditions.

My first exposure to the role of physiotherapy in neurology was a position on an acute spine unit. Initially, I felt overwhelmed but also intrigued and excited. With a diverse patient population, skills from each of the major areas of physiotherapy are required. Currently, I am working at GF Strong Rehabilitation Centre on the Acquired Brain Injury inpatient unit. I am able to build on the knowledge I gained working on the spine unit while continuing to develop my skills. The atmosphere supports continued learning, with collaboration among team members an integral part of our daily clinical work.

Working in public practice has given me a unique perspective and insight. Helping patients prepare for discharge often highlights gaps in community services for this population. Many of these individuals were previously active in leisure pursuits, but are no longer able to find suitable activities. In the fall of 2011, I joined the team at Neuro-Ability, a private practice in Vancouver dedicated to best practice in neurological rehabilitation. Along with Jean Cremin, a neurological physiotherapist who is a trained Pilates instructor, we lead group-adapted Yoga-Pilates classes. There was overwhelming interest in the classes as they offered a unique opportunity for people with neurological conditions to be active and involved with their peers. As one of the participants remarked: “After my stroke I had tried to resume ‘normal’ yoga classes but found the pace too fast. Many of the instructors I approached dismissed the idea of me doing yoga. Consequently, I was delighted to hear of these classes.” (C.C.) The classes will be offered again in February 2012.

If I had to predict future trends, I anticipate maintaining a position in public practice while pursuing other interests. For example, I see the potential to combine my past experience in competitive sports with my current interest in neurological physiotherapy to work with athletes with disabilities. I also look forward to growing and developing the adapted classes at Neuro-Ability to best meet the needs of this population.

PABC and CPTBC are co-hosting another annual day of education and connecting with peers. Hold the date and you’ll be glad you did. Each year attendees rave about the high value they place on the experience.

Register by March 31st and receive a free lunch. Registration thereafter will be charged $20*.

This year, we are asking PABC members to offer billeting so colleagues from outside Vancouver can ease their accommodation expense. Email rbt@bcphysio.org if you have space or would like space.

Program

- 7:30 Registration, Coffee, Trade Show
- 8:30 Diane Lee, Evidence Based Practice: Are We Advancing or Impeding Treatment?
- 9:30 Stretching Your Views of Stretching (Alison Hoens, Dr. Ada Tang, Nadine Nembrard, Deb Monkman)
- 10:15 Coffee, Trade Show
- 10:45 PABC AGM
- 12:00 Lunch and Trade Show
- 1:00 Neil Pearson, Pain Science: Challenging PT Theory & Practice
- 2:00 CPTBC AGM
- 3:00 Refreshments, Prizes
- 3:30 UBC-PT Dept, Rapid Research
- 4:15 Wine and Cheese Reception, UBC-PT Dept sponsored

*The late registration fee is to cover the expense associated with hotel catering deadline requirements.
Phisiotherapy Information at Your Fingertips – on the Members Site: What’s In It for You?

PABC’s Knowledge Team is unique in the entire world. No other provincial professional association has a librarian, and none has a Knowledge Broker. Certainly no physiotherapy association nationally or internationally has the combination of both. When we add in our Member Services Manager Jesse Royer, we have a Knowledge Team that exists only in BC. Our PABC power trio brings you free information services. If you haven’t explored our Knowledge Centre & Library on the members’ website in depth, here’s a chance to review what you’ll find there. Visit www.bcphysio.org, login as a member, click on Knowledge Centre & Library, and then use the left menu to explore these resources created by our knowledge broker Alison Hoens and me.

1. What’s New
   • Watch this constantly-changing area for what’s been added recently by Alison or me. You’ll also find my eBlasts here.

2. PABC Knowledge Team
   • Do you know your Knowledge Team? An introduction to Alison, Jesse and me, and to our unique approach to serving you

3. Knowledge Broker
   • What does Alison do to help your clinical practice?
   • Updates and information about knowledge broker projects (see Alison’s article in this issue of Directions for more)

4. Library Databases & Journals
   • Tips for beginners and those who want more details about how the library service works for members
   • Access databases and full-text journals (Medline, CINAHL, Cochrane Library, etc.)
   • Hot topic alerts and how to set them up

5. Training – Webinars & Tutorials
   • Evidence-informed practice training – webinars and tutorials on finding and appraising the journal literature, developed especially for PABC members
   • Database training – more help for lit searching
   • Social media training – all things “Web 2.0” from PABC, from social media webinars to useful physiotherapy Communities of Practice

6. Patient Education
   • Patient education videos, kindly provided by BC’s Active Life Physiotherapy
   • Downloadable patient education materials (customize with your logo, print or post on your sites)
   • Links to good physiotherapy patient education materials

7. Toolkits & Best Practices (most popular links in the Knowledge Centre & Library!)
   • Cryotherapy, electrophysical agents, safe mobilization, PT skin and wound care, total joint arthroplasty outcome measures
   • Back strain model of care
   • Management of spasticity: botox
   • Safe handling of patients toolkit
   • Whiplash and associated disorders kit

8. Research Collaboration Registry
   • View a listing that connects clinicians, decision-makers and researchers for physiotherapy research opportunities.

9. Links
   • Save your time and link directly to good physiotherapy resources.

Now Where Did I Read That?
A New Index for the Directions Article of Your Choice
“Didn’t I read something about shockwave therapy? Physiotherapy in China? PABC’s brand? How to use social media?”

You know you’ve read it — somewhere in Directions — but where is that article about lifetime physical activity, joint vulnerability and osteoarthritis? Or maybe you’ve authored articles. Now you can access the wealth of information in past issues of Directions by logging on to the PABC members site. Look under “Communications” for current and back issues of Directions, along with the new subject and author index.

PABC Knowledge Team
Excited to Have Conference Paper Cited
by Deb Monkman, Alison Hoens, and Jesse Royer

Conference presentations come and go and it’s not always the case that one’s hard work is acknowledged beyond the event. We’re happy to report that the Knowledge Team’s paper, presented at the Canadian Health Libraries Association (CHLA) conference in May 2011, has been cited in a recent paper on “Using evidence in practice” by Andrew Booth in Health Information & Libraries Journal. Referring to our paper, Booth says the “multidisciplinary and multi-authored contribution attests to the power of the team approach.”

As we know, PABC’s knowledge team approach to promoting evidence-informed practice among members is unique — and now more people will know about it too!

See our paper at: www.chla-absc.ca/2011/node/166
Can You Out-Google Your Friends?

Spend half an hour learning tips and tricks for getting the most out of Google. Watch the recording of PABC’s *How to Out-Google Your Friends webinar*, at your convenience, on the members site.

Go to Knowledge Centre & Library > Training – Webinars & Tutorials > Social Media Training.

**Member Kudos for Librarian Services**

**Webinars**

I really appreciate you doing the webinars and in 2012 I resolve to attend the webinars in 2012.

I definitely like the webinars that I can watch at my leisure. As I work for myself, there are all sorts of things going on and sometimes the time that a webinar is scheduled seems good, but then something comes up that has to be attended to. I do, though, want very much to get in on the research webinars.

Great sessions - love the podcasts and the library of podcasts!!! Great to come back to stuff when I have the time.

I think they are great for busy people, people who live in rural areas and can’t get to the city for other educational sessions.

The webinars I’ve attended have been truly awesome and even more so because they’ve been free.

Keep up the good work, PABC HAS COME A LONG WAY!!!

PABC had the honour of presenting the 2011 MPT graduation class with a host of awards at their November convocation reception. In addition to the following awards, PABC presented each student with a PABC embossed padfolio and their first physiotherapist business card. Welcome to our 68 new physiotherapy colleagues, and congrats to these award winners:

**Yvonne Lynch:** PABC Prize for the highest cumulative standing in all case-based integration course work.

**Sarah Stroh:** Amanda Reid and Rick Hansen Award for promotion of the profession through the active involvement in PABC initiatives.

**Tony Gui and Colin Beattie:** PABC Leadership Award for demonstrated leadership, and unique and innovative contribution to the profession.

**Julia Wierczkowski:** CPA award for second highest academic standing for the program

**Kevin Turpin:** CPA Paediatric Award for demonstrated excellence in academic and clinical paediatrics.

**Emily Mitchell** was recognized by UBC with the Outstanding Academic Achievement Award.

Clinic Name Change

Siobhan O’Connell has changed her clinic name in order to bring it in more clear alignment with their three core services — Trimetrics: Physiotherapy Clinical Pilates and Complementary Health. www.trimetricsphysio.com.

Gotta Run! Meeting at the Victoria Half Marathon start line in front of the Legislature are L-R: Rebecca Tunnaciffe, Megan Markewich, Sarah Hrabi, Patricia Otukol, Anne Rankin

Physiotherapist by day, rap artist by night, Carlie Rompre (Baby C) created a rap song and video with PABC’s financial consultants Alim and Bradley of Healthcare Financial. See the video at www.bcphysio.org/members home page.

Carlie leads the PABC staff and the Healthcare Financial fellows through her Physio Rap, L-R: Alim Dhanji, Jesse Royer, RBT, Carlie, Deb Monkman, Stephanie Dutto, Bradley Roulston

Really like the webinars and have learned from all that I have attended.

The webinar format is fantastic! As a busy clinician with a busy family life I love how convenient and useful they are.

I have attended one webinar and it was very good, so I registered for the shoulder journal club.

Webinars are a valuable educational resource both for being informative and promoting collaboration.

The webinar I attended was great and I loved being able to do it at home.

**Monthly E-Blasts**

Your December 2011 Librarian eblast had some great info! I am looking into the ‘Papers’ organizing app that was recommended by Diane Lee. CH

Great info coming from the Librarian e-blasts. GC

I’ve heard GREAT things, and now I’m a first timer accessing your services! I feel so grateful to have you working for us all. JD

**Siobhan O’Connell** has changed her clinic name in order to bring it in more clear alignment with their three core services — Trimetrics: Physiotherapy Clinical Pilates and Complementary Health. www.trimetricsphysio.com.
Do You Like Us? Why PABC’s Social Media Matters

by Jesse Royer, MLIS, Member Services Manager

that promoting you and your unique contribution in health care is best done through Facebook, which leads to our website, our Twitter site, and also our microsite for the public at www.moveingforlife.ca. The more LIKES we have, the more people we will reach, and the more credibility BC physio will have in terms of SM metrics.

We have been talking to you about SM for several months now, and many of you have taken our advice by joining Facebook, LinkedIn, Twitter, and other SM networks and are interacting with colleagues and PABC. If you have questions about how to get started on social media or how to expand your presence and learn some new tricks, read on!

In the Fall of 2011, RBT and PABC President Scott Brolin toured BC to meet members and provide an update on what we’ve been doing on your behalf. Rebecca’s presentation on our SM generated great enthusiasm. She mentioned our free Cool Tools for Physios webinars that we ran last summer, focusing on Facebook, Twitter, and searching with Google, and we saw a spike in views of the webinar recordings (www.bcphysio.org/members Knowlegde Centre & Library section). She mentioned that she’s posting PABC members (daily!) on our Facebook page, and we are hearing from members we didn’t even know were SM hip! We started a group on LinkedIn and right away we had members joining in on the conversation.

In other words, the proverbial ball isn’t only rolling, it’s moving fast and gaining momentum.

Our SM activity is about increasing physiotherapy exposure. On Facebook, on Twitter, on LinkedIn, on YouTube, physiotherapy discussions are taking place every day. We use our SM presence to talk about new research and ideas in physio, connect members to each other, keep tabs on other associations, and best of all, check out what you, our members, are up to. By joining the SM world, you will find easy access to your patients both current and future.

All of PABC’s SM sites are fully visible to anyone and don’t require you to have an account of your own to follow along with PABC; you can view our pictures and posts without one but you can’t participate. We do suggest that you get an account for Facebook to start (and we can help you do so. Call or email me at the office; we’ll get you taken care of) so you can be part of the action.

Check out our SM pages and you’ll get a glimpse of members’ activities. Also send us your action pix for active living and see yourself with your PABC peers on our Facebook page.

Facebook: facebook.com/bcphysio
Twitter: twitter.com/pabcinfo
YouTube: youtube.com/bcphysio
LinkedIn: linkedin.com/company/physiotherapy-association-of-british-columbia

Knowledge Broker Update

by Alison Hoens, Physical Therapy Knowledge Broker, MSc, BScPT, PG Sports PT

As we pack away the Christmas decorations and herald in the new year of 2012, I have been reflecting on all the achievements of so many of our BC PTs that sit like presents under the tree waiting to be enjoyed by PABC members. The table on the next page summarizes some of these gifts which can be found on the PABC website. If you have any questions about any of these resources, please contact me at alison.hoens@ubc.ca. A special thank you to all those who have so willingly given of their time and talents to help develop these wonderful resources. I look forward to working in 2012 with many of you on resources that we can put under next year’s PABC Christmas tree.
# A Summary of PABC’s Knowledge Team Web Resources Available

<table>
<thead>
<tr>
<th>Resource</th>
<th>Purpose</th>
<th>Who is it for?</th>
</tr>
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<tbody>
<tr>
<td><strong>Cryotherapy: Why, When &amp; How</strong></td>
<td>A 2-page decision-making tool to guide safe and effective application of cryotherapy and other interventions to manage pain, inflammation, edema and swelling</td>
<td>Members working with patients who have acute and subacute injuries</td>
</tr>
<tr>
<td><strong>Electrophysical Agents: Contraindications and Precautions</strong></td>
<td>An 81-page decision-making tool to guide safe application of electrophysical agents</td>
<td>Members working in any setting with electrophysical agents such as TENS, NMES, Ultrasound, LLLT etc.</td>
</tr>
</tbody>
</table>
| **Safe Mobilization (SAFEMOB)** | • A decision-making tool to guide safe mobilization of acutely ill patients  
• An inventory of literature and links to support the use of the SAFEMOB tool  
• Recording of webinar demonstrating how to use the SAFEMOB tool | Members working with acutely ill patients |
| **Skin & Wound – Use of electrical stimulation and ultrasound to promote wound healing** | • Recording of lecture outlining the theory and evidence for use of electrical stimulation and ultrasound to promote wound healing  
• Recording of a practical demonstration of how to apply electrical stimulation for wound healing  
• A detailed list of required equipment  
• A step by step written guide for the application of electrical stimulation  
• A list of important references  
• Links to additional resources | Members who treat patients who have surgical or nonsurgical wounds. |
| **Outcome Measures for Total Joint Arthroplasty** | An inventory of valid, reliable, sensitive and specific outcome measures including information on what they measure, who to use for, how to use them and how to score them | Members who work with patients who have had a total hip or total knee replacement |
| **Outcome Measures Databases** | List of links to databases for rehabilitation-related outcome measures | Members looking for an outcome measure to assess and reassess patient outcomes such as balance, strength and function |
| **Safe Handling of Patients** | • A series of four ‘alerts’ with key information to guide safe handling of patients in acute care settings  
• Inventory of resources/links with supporting information on specific lifting and handling devices | Members in acute care, rehabilitation and residential settings |
| **Botox for spasticity management** | • Algorithm to guide OTs and PTs working with adult patients and residents who have spasticity and for whom the team is considering using Botox to reduce tone.  
• An inventory of outcome measures which can used to determine the effectiveness of the intervention(s). | Members working in rehab, community and residential settings with patients/residents who have increased tone. |
| **Incentive Spirometry: evidence-informed practice** | A two-page clinical resource developed by physiotherapists at St. Paul’s Hospital to provide evidence to other team members for the choice not to have incentive spirometry available | Members working in acute care settings |
| **Secretion Clearance Techniques: evidence-informed practice** | A two-page clinical resource developed by physiotherapists at St. Paul’s Hospital to provide evidence to other team members for when secretion clearance techniques are not appropriate | Members working in acute care settings |
At WCPT Congress in Vancouver in 2007, I sat in a number of sessions wherein presenters stated that clinicians were not aware of or practicing as per the latest published guidelines, or were not aware of the research. As a clinician myself, I recalled how frustrated my own public sector colleagues were at the difficulties in accessing literature.

At that time, I was the PABC President and knew that the Association was about to purchase access for all of its members to the Electronic Health Library of BC (eHLbc) thereby providing access to biomedical databases and full-text journals.¹ The previous year, PABC had hired a librarian to help its members access the literature. I wondered if providing access to the eHLbc would make a difference, and proposed that we discover from PABC members prior to the introduction of eHLbc what the perceived barriers may be to reading journal articles.

Previous studies had looked at physiotherapists’ perceptions of barriers to doing research or applying research evidence in practice (Grimmer-Somers et al. 2007; Wiles and Barnard 2001), but none had looked at access to the literature. Jette et al. (2003) investigated “self-reported attention to the literature,” including number of articles read per month. Although Jette et al. (2003) also looked at use of literature for decision-making and the use of Medline or other databases, they did not investigate barriers to reading journal articles.

At the start of this study, physiotherapists working in private practice in British Columbia (at least 50% of practicing physiotherapists) did not have access to full-text articles, unlike many of their counterparts in public practice who had access through hospital and health authority libraries.

The purposes of this study were (1) to determine BC physiotherapists’ perceptions of factors influencing their ability to read journal articles, and (2) to assess change in perceptions after providing access to the eHLbc databases and full-text journals. The novel aspects of this study were that it specifically focused on barriers to reading journal articles, not those to evidence-based practice (EBP) in general, and that we conducted a survey before and after providing access to full text articles and databases via eHLbc.

The research questions for the study were:
1) What do physiotherapists practicing in BC perceive to be the top three barriers to reading published journal articles?
2) Is there a difference in the top three barriers after providing access to eHLbc databases and free full-text journals?

Methods
A short paper survey was developed by PABC librarian Eugene Barsky and me. Selection of survey recipients was random, with every fifth PABC member with an email address selected, resulting in 200 recipients. We re-administered the same cover letter and survey one year later (11 months after access to eHLbc). At both time points, survey recipients received a postage-paid, addressed, return envelope to return the survey, and received an email reminder to trigger completion. The study was approved by the University of British Columbia (UBC) Ethics Review Board.

The survey questions included:
1. What is your current physiotherapy practice/role (public/private/combo/research), year of graduation and highest PT qualification?
2. Do you currently have access to full-text journal articles (a full-text journal article is defined as at least one full page not including abstract)?
3. Please select, from the list below, the three most important factors influencing your ability to read journal articles. If there are ‘none’ then please select ‘none’.

Important Factors – List of Options:
- Time
- Restricted access to databases to find articles
- Restricted access to full text journal articles
- My ability to search and retrieve relevant articles
- Restricted access to a specific journal (please list)
- My ability to understand journals
- Cost/money
- Other
- None

Results
The response rate was 91/200 at baseline (45%). Sixty-eight members also responded at one year and 34% responded both at baseline and one year. The age range was 24-74 years, with a mean age of 43 years (SD = 11 years). Seventy-four percent were female and 26% were male. Over half of respondents (56%) worked in private practice while 23% were in public practice, 12% were both public and private practice, 4.5% were research, and 4.5% were missing this data.

¹ PABC subscribes to eHLbc’s core suite of products: OVID Medline, OVID Evidence-Based Medicine Reviews (EMBR), EBSCO CINAHL with full-text, EBSCO Medline with full-text, EBSCO PsycINFO, PsycARTICLES, EBSCO Biomedical Reference Collection, and LWW Total Access Collection.
“Do you currently have access to full text journal articles?”

At baseline, almost half of respondents (47%) said they had access to full-text articles. At one year this had risen to 78%. Forty-five percent did not have access at baseline, and 19% at one year. No answer was provided by 7% (baseline) and 1% (one year).

“Three most important factors influencing your ability to read journal articles”

Time was the most important factor influencing the ability to read journal articles at baseline (87%) and also at one year (88%). Restricted access to full-text articles was a barrier for 45% of respondents at baseline, reducing to 32% at one year. Likewise, restricted access to databases was noted by 20% at baseline, and reducing to 12% at one year. However, ability to search and retrieve was 15% at baseline and increased to 32% at one year. See Table 1 for a summary.

Table 1: Three most important factors influencing ability to read journal articles

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Baseline</th>
<th>1 Year Later</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>87%</td>
<td>88%</td>
</tr>
<tr>
<td>Restricted access to full-text</td>
<td>45%</td>
<td>32%</td>
</tr>
<tr>
<td>Restricted access to databases</td>
<td>20%</td>
<td>12%</td>
</tr>
<tr>
<td>My ability to search and retrieve</td>
<td>15%</td>
<td>32%</td>
</tr>
</tbody>
</table>

Discussion

Time was consistently a top issue with no change between the pre- and post-survey. Time is a factor, so if it takes ten steps to retrieve an article then that could influence knowledge of research findings and eventually uptake or change. However, a recent study by Groth (2011) provided evidence that workload (a significant contributor to available time) may not be as powerful a predictor of the intent to use research evidence as traditionally thought. Indeed, Groth’s work suggests that it may be more important to support therapists by providing strategies to highlight how the evidence is relevant to their clinical practice and to highlight the use of the research findings by respected colleagues. This suggests that ‘getting’ and ‘reading’ the articles is only the first step. We need to support therapists’ abilities to appraise and apply the research after we provide access to it.

Restricted access to full-text articles was a top barrier which was reduced after eHLbc’s suite of databases and full-text journals was introduced. Likewise restricted access to databases was a top barrier which was also reduced after the introduction of eHLbc. However, the ability to search and retrieve articles almost doubled one year after access to eHLbc, suggesting that as access became a lesser barrier, a new barrier emerged in that respondents needed to then know how to find relevant literature now that they had access to far greater resources.

Other studies (Grimmer-Somers et al. 2007; Wiles and Barnard 2001) have investigated clinicians’ use of the evidence but do not address whether participants have access to full-text articles. Yet in practice, if access to the evidence is not simple then it is indeed a barrier. Other studies have also addressed similar barriers to using the literature for evidence-based practice but the questions were different. Bennett et al. (2003) describe barriers to implementing EBP by occupational therapists: lack of access was fourth and lack of skills was fifth. Jette et al (2003) listed similar top three barriers but their question was related to use of EBP in clinical practice.

Study limitations include a response rate of 34% pre- and post-implementation; this is, however, similar to other studies (e.g. Iles and Davidson 2006). The mean age of survey respondents was young (43 years).

Conclusions

Restricted access to full-text articles is a barrier that was, although reduced with eHLbc, still a factor one year later. This could be related to the time it takes and steps involved to get access to full text, lack of experience or knowledge about how to retrieve the full text, or the fact that in spite of increased access to full-text articles through eHLbc, not all articles are available. Increased full-text access would increase the costs to members for providing eHLbc. As an alternative, PABC offers the services of a librarian who can retrieve articles from additional sources (beyond eHLbc).

Time remains the biggest barrier. There seems to be no easy solution to this problem, although the ease of technology and fit with busy lifestyles should help.

Once PABC members had access to databases and journals, their ability to search and retrieve was perceived as one of top three barriers to reading articles at one year. PABC has worked hard to address this need by having their Librarian and Knowledge Broker providing webinars on how to search and appraise the literature effectively.

References


Member Use of eHLbc: A Tracking Study
by Deb Monkman, PABC Clinical Librarian

In addition to, and independent of, the survey conducted by Dr. Sran was a side-project by the PABC librarian at the time, Eugene Barsky. Eugene was curious to know the level of interest and activity of PABC members with their new access to eHLbc. He tracked the number of times a PABC member accessed an eHLbc database at three time points: 1) when the physiotherapists are first given access to eHLbc; 2) six months later; 3) one year later.

The number of searches of eHLbc databases in the first month (September 2008) was 838, climbing to its highest number of 1,951 in November 2008 (see Figure 1). Overall, database searches did not increase much above the baseline in the first year. However, what is perhaps most notable is that during a gap in librarian service to members from February through May (due to a change in librarians), searches decreased significantly, only to rise again when service levels resumed. The PABC librarian did not use eHLbc databases, using UBC databases instead so that these numbers reflect member use only. This suggests that the PABC librarian’s roles in promotion, training and support may affect searching by members.

Figure 1:

In reviewing Eugene’s findings, and together with my own observations on the job for the past 2 ½ years, I conclude that access to high-quality literature is of utmost importance to PABC members. This access needs to be easy and relevant. Although one may be tempted to just ‘Google it’, a recent article by Kingsley et al. (2011) clearly demonstrated that dental students who used Google to complete a search for an assignment provided a statistically significantly higher percentage of incorrect responses than those who used PubMed as their database for the search. Finally, access alone is not enough. Support for appraising and applying the findings to practice is also required.

PABC is addressing all three components through its Knowledge Team of Jesse Royer (Member Services Manager), Alison Hoens (Knowledge Broker) and myself.

References
Do You Know the True History of our Profession? We are Older Than You Think

by Patrick Jadan, MScPT CSCS CAFCI

As a member of PABC’s Business Affairs Committee, I was given the task of reviewing some literature in preparation for our discussion on “where is private practice headed in the coming decade?” I quickly became fascinated with our profession’s history and how it can inform our view of our future. I was also excited to learn that our profession has roots back to the early 1800’s (not the 1930’s as we have come to think) and was the originator of orthopaedic medicine and manipulative therapy.

According to the International Federation of Orthopaedic Manipulative Physical Therapists (IFOMPT), our current practice of orthopaedic manipulative physical therapy was originally an offspring of orthopaedic medicine [1]. Orthopaedic medicine is thought to have originated in 1929 at St. Thomas’ Hospital in London, England [2]. At this time, Dr. James Cyriax (1904-1985) experienced an “epiphany” which led him to develop a system of assessment and treatment that would earn him the title of “father of orthopaedic medicine”. However, a scientific paper by Anders Ottosson, a medical historian from Sweden, published in Medicine Studies in December of 2011, is challenging this historical viewpoint [3].

Ottosson contends that Dr. Cyriax intentionally repressed knowledge of the long history of physical therapy that pre-dated his 1929 epiphany by more than 100 years. Ottosson shows that Dr. Cyriax’s father was a physician but also a trained physical therapist. Furthermore, Dr. Cyriax’s grandfather, Jonas Henrik Kellgren, was one of the most famous physical therapists of his era and even treated the daughter of Mark Twain.

Yes, that’s right…I said physical therapists in the 1800’s.

Before there was orthopaedic medicine there was in fact physical therapy.

Both Cyriax’s father and grandfather were trained in Sweden at the Royal Central Institute of Gymnastics (RCIG), which was established in 1813 by Pehr Henrik Ling (1776-1839). Students of the RCIG were given the mission to help spread this revolutionary method around the world. Cyriax’s ancestors were among these alumni. Ottosson credits Ling with establishing both what we now know as physical therapy, and orthopaedic medicine. He even contends that osteopathy (founded by Andrew Still in 1874) and chiropractic medicine (founded by D.D. Palmer in 1894) were likely offshoots of Ling’s physical therapy. He further notes that during the middle of the 1800’s the physical therapy profession in Sweden was largely made up of men who held the title of doctor and were held in higher esteem than physicians. However, a series of events, starting with Cyriax’s claim, led to medicine dominating physiotherapy. Physicians then began dictating the educational content, granting licensure, and controlling access to patients with a prescriptive relationship.

So what does this all mean? Well, it provides very compelling evidence that up until now the true history of our profession has been repressed. Initially, we were an autonomous profession with very different demographics and status. We pre-date orthopaedic physicians, chiropractors and osteopaths.

So, how do we use this new information? Well as the old saying goes, “you don’t know where you’re going until you know where you’ve been”. This rich history should encourage us, as a profession, to strive not merely for modest gains but to lobby and advocate for truly autonomous practice.

I encourage all PABC members to read through the full version of Ottosson’s article. This is our story, and we need to reclaim it. My brief summary barely scratches the surface of the great research he has done. I hope that reading it will inspire you as much as it did me.

Patrick practices at South Cowichan Physiotherapy in Cobble Hill, on beautiful Vancouver Island. He is a member of the PABC’s Professional Development Advisory Committee as well as its Business Affairs Committee, and is running for the CPA Board of Directors.

References
1. http://www.ifompt.com/About?IFOMPT/History.html. These historical facts have recently been removed from IFOMPT’s web page which now only contains a historical survey from the 1960s and onwards. The part on St. Thomas’ Hospital, now “lost”, was however mainly taken from: Paris (2000) – see reference below.

Update from WorkSafeBC

1) Good News: CMS is now working well with over 85% of invoice transactions being processed within 30 days;
2) Claims info is readily available at www.worksafebc.com/claims/managing_claims/view_claims where you’ll learn:
   • Whether or not the claim is allowed, and whether Stream 1 is allowed
   • The body part and injury that is accepted and eligible for physio

In order to view this information, you will require your Payee number, worker’s claim number and PHN.

WorkSafeBC thanks you for your commitment to providing the highest quality service to Injured Workers!
New “Open” MRI at UBC is Opening Up Possibilities for Arthritis Research

by Erin Macri, MPT,BSc(Kin)

Did you know that, for people reporting knee pain, if a lateral or skyline view radiograph is added to traditional posterior-anterior (PA) X-rays, the incidence of radiological patellofemoral joint OA (either isolated or in combination with one or both tibio-femoral compartments) is 64%?¹

Did you also know that almost a quarter of people with knee pain have radiographic evidence of isolated patellofemoral joint OA [1]? It is a diagnosis that is often overlooked since common practice is to obtain PA X-rays alone for diagnosis. Not only that, but the presence of patellofemoral OA predicts progression of generalized knee OA (i.e. osteophyte growth and joint space narrowing) over as little as 30 months [2]!

As physical therapists, we are all well aware of the effects of anterior knee pain on function and quality of life. What if we could find a way to identify people at risk for knee OA at an early enough stage that we could prevent it, or at least significantly alter the trajectory of the condition?

Measuring patellofemoral kinematics using MRI technology has certainly been done; however research to date has generally been done using a closed bore MRI, where participants were scanned in supine. This imaging method has several important limitations: (i) it limits the range of knee motion that can be analyzed; (ii) weight bearing is limited to less than 30% of physiological load, and (iii) the patient cannot adopt functional positions through the lower extremities [3-6]. Until now, it has been impossible to measure true patellar kinematics in functional positions under normal physiological loads.

This past summer, UBC’s Centre for Hip Health and Mobility finished installing a new MR instrument called the MROpen (Paramed, Fig. 1a). We are thrilled to report that this is the first of its kind being used worldwide for research purposes. The magnet is u-shaped and therefore “open to the sky”. This means that for the first time, we will be able to measure kinematics of the knee while a participant is fully weight-bearing, in a variety of positions relevant to activities of daily living. This is an improvement over previous generations of “vertically open” MR instruments, which were designed for intervention rather than research, and had a bar across the top that prevented full natural upright stance (0.5T Signa, GE see Fig. 1b).

Now as a UBC graduate student, I hope to use this open MR instrument to elucidate kinematic factors that may influence the onset and progression of PFJ OA. Having just received a research fellowship award from the Australian Government, my plan is to spend several months studying with anterior knee pain expert Dr. Kay Crossley at the University of Queensland, then return to Vancouver and begin recruiting participants. My hope is that this research can help improve awareness of risk factors for knee OA that, through earlier detection and optimal physical therapy intervention, will help patients maintain health and happiness for years to come.

Erin graduated with the first MPT cohort at UBC in 2006. Since then, she has worked in private practice both in Canada and New Zealand. She returned to UBC this year to pursue graduate studies with Karim Khan at the Centre for Hip Health and Mobility. erin.macri@hiphealth.ca.

References:

Erin Featured at TEDx

Erin Macri was a speaker at TEDx Vancouver in November. TEDx focuses on local thought leaders and is under the umbrella of the famous TED Talk series on “ideas worth spreading.”

Erin spoke on how her drive to serve the community and inspire people to explore their potential led her and co-presenter Jai’ Aquarian to design and build the largest stick-frame wooden structure on the planet, the Temple, in the middle of a Nevada desert with team members from 17 countries this past summer.
Expanding Our Reach to Northern BC

by S. Jayne Garland, PhD PT, Professor and Head, Department of Physical Therapy

There has been extensive discussion between Government, UBC and UNBC regarding various options for distributing the Master of Physical Therapy (MPT) program to fulfill our role as BC’s provincial Physical Therapy educational program and to contribute to improving health care provider coverage in northern and rural areas of BC. Funding is now in place to allow 20 UBC MPT students to complete most of their clinical placements in northern and rural communities each year, with UNBC serving as the clinical education hub. UNBC is building a new physical therapy teaching laboratory that will be linked by video with three similar teaching labs at UBC as well as other hospital and health facilities that are part of the UBC Faculty of Medicine’s distributed medical education program. The UNBC facility will also be a focal point for continuing professional development for northern and rural physiotherapists. The first northern and rural cohort will begin their two-year education at UBC’s Vancouver campus in September 2012, and begin their first placements the following spring. The northern and rural cohort students will be selected through revised admissions policies designed to target students with an interest in living and working in those areas. Our thanks go to Terry Fedorkiw for her persistence and passion, as she was instrumental in bringing this proposal to fruition.

With this expansion we are looking for quality clinical educators to work with students on rotations in clinic. Anyone interested in learning more can access a variety of resources in the clinical education area of our website: http://www.pt.med.ubc.ca.

Our long-term vision of creating a fully distributed MPT program with classroom components taught synchronously at multiple locations remains on our roadmap and we hope to see this develop in the future.

Clinical Education: The Dreaded CPI!

by Sue Murphy, B.H.Sc (PT), M.Ed., Associate Head, Clinical Education

We have heard (loud and clear!) that the current evaluation form we use for student placements (the “CPI”) is frustrating for clinicians. Common complaints are that it is too long, too repetitive, and unsuited to the Canadian Healthcare context. The CPI has historically been used because it is reliable and valid, and used by PT programs across Canada. There has been extensive discussion between the programs as to a more effective tool; however, programs were unable to reach consensus. A new “Pan-Canadian tool” is being developed which will be used by all the programs in Canada once tested and validated. However, as this is likely to be a somewhat lengthy process, we recognize the need for a timelier alternative to the CPI.

The alternative we plan to offer is the Australian APP (Analysis of Physical Therapy practice) form. It is a much shorter evaluation tool and has been adapted for use in the Canadian context. This form will be a TEMPORARY alternative to the CPI — we will, along with other Canadian programs, adopt the new Canadian tool once ready. In the meantime, supervisors will be able to choose whether to use the APP or the CPI form.

In order to offer this as an alternative, we need to prove that evaluation is equivalent on both forms (i.e. students don’t get a better or worse grade on one form than the other). We therefore need volunteers willing to fill out BOTH forms on a student over the next few months. We hope to then offer the APP alternative for use next fall.

If you would be willing to pilot the APP form with your next student, please email me — I would love to hear from you!

I’m Tori, Your Student Physio Today

by Patricia Otukol, MPT2 Student Columnist

Each therapist has a unique story about why they chose this career. There are few stories that are more compelling than that of Victoria (Tori) Feige, a fellow MPT2. At 18, Tori, took a rough landing while snowboarding and sustained a burst fracture of her T12 vertebrae. After her accident, Tori was left with a T12 incomplete spinal cord injury, making her decision to become a physiotherapist that much more noteworthy. According to Tori, she does not present like a typical T12 SCI; she uses a wheelchair, but she is able to stand beside a plinth or hospital bed with AFOs, and walk about 2km with poles. I got the chance to ask Tori some questions about the program and her journey as a physiotherapist thus far:

Why did you choose physiotherapy as a career?
So many reasons! But essentially, I really like the science of movement and physicality of the job.

How would you describe your experience as an MPT student?
My experience in the program is far more similar to a regular student than it is different! My classmates are great and the chair is a non-issue. I get to study what I love with my friends — it’s a pleasure really.

If patients/clients respond to you differently, how do you put them at ease?
I use communication, mainly. Both verbal and non-verbal communication is important, I think.

What are the most important strategies you use to ensure your success in clinical practice?
I modify the environment to provide greater stability and safety for the patient and also myself. If I still have concerns, I change the task or get another person. It all comes down to person, task, and environment.
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– BC’s Directions in Physiotherapy : Winter 2011


**Continuing Education at the Mary Pack Arthritis Program**
The Mary Pack Arthritis Program is offering a 4-day workshop to assist practitioners in gaining basic knowledge and clinical skills to assess and manage three common rheumatic diseases: rheumatoid arthritis, osteoarthritis, and ankylosing spondylitis. The details for this educational event, **Introduction to the Assessment & Management of Rheumatic Disease: A Skills Workshop for Physical Therapists,** are outlined below:

- **Date:** March 5th - 8th, 2012,
- **Place:** Vancouver Hospital, **Cost:** $500
- **Registration Deadline:** February 3, 2012
- **Registration info:** (604) 875-4111 ex 68830
  Paul.Adam@vch.ca
- **Course Content info:** (604) 875-4111 ex 68834
  Marie.Westby@vch.ca

**Overcome Pain: Knowledge and Gentle Yoga Retreats, Level 1** are offered in 2012 in Naramata, north of Comox, and on Salt Spring Island. These retreats allow your patients to immerse themselves in safe effective practices to decrease pain and improve quality of life. Through knowledge of chronic pain and practising Yoga techniques, people are empowered with practical tools to wind down their nervous systems and promote positive, lasting changes in their body. Facilitated by Neil Pearson, physiotherapist, yoga therapist and educator, these sessions provide individuals with unique plans to enhance outcomes and allow continued improvements. Approx. cost for 4 day retreats - $460 and up.

The focus of Level 1 is on breathing techniques, body awareness and gentle movement. Level 2 focuses on using Yoga practices to challenge physical ability and function.

No Yoga experience is required. Individuals must be independently mobile. The Yoga practices are gentle and interspersed with discussions and rest periods.

More info at www.lifeisnow.ca, click on Yoga Retreats. Or email Neil at info@lifeisnow.ca.

**Pilates For Health Professionals**
These courses form the link between evolving research in stability training and traditional Pilates work. They are structured to give you a toolkit that will enable you to deal effectively with early stage rehabilitation progressing to more dynamic and specific training.

The many variations of the traditional Pilates repertoire will be broken into key components and you will learn to quickly and effectively select pathology specific exercises. Building upon these foundations you will then be able to develop a logical sequence in movement selection.

This program is designed by physiotherapists for the health care professional. Places are limited, so early booking is advised.

- **Level 1:** (2.5 days) March 2(eve)/3/4 or April 20 (eve)/21/22 - $475+HST
- **Level 2:** (2 days) March 31/April 1; May 5/6 - $350+HST
- **Pilates for Pregnancy and Postpartum:** March 31 - $175+HST
- **Venue:** North Vancouver

**Presenters:**
- Susie Higgins, non-practising registered Physiotherapist, Bodycontrol Pilates Instructor
- Margaret Bowden, non-practising registered Nurse, Polestar Pilates Instructor

For further information on full mat certification and to register for any of the courses, contact Susie Higgins: ph: 604 970 1057 or email: evolvedpilates@shaw.ca

**Privately Sponsored Courses**
Details at www.bcphysio.org - Courses and Events

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<td>• NOI Graded Motor Imagery Course, North Vancouver</td>
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<td>• Functional Anatomic Palpation Systems™ Spine, Vancouver</td>
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<td>• Introduction to the Assessment &amp; Management of Rheumatic Disease: A Skills Workshop for Physical Therapists, Vancouver</td>
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<td>• 28th International Seating Symposium 2012, Vancouver</td>
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<td>• Overcome Pain: Knowledge and Gentle Yoga Retreat, Level 1, Naramata, BC</td>
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<td>• The International Fascia Research Congress, Vancouver</td>
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<td>• Overcome Pain: Knowledge and Gentle Yoga Retreat, Level 1, Comox, BC</td>
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<td>• Myokinematic Restoration: An Integrated Approach to the Treatment of Patterned Lumbo-Pelvic-Femoral Pathomechanics, Vancouver</td>
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<td>• Physiotherapy Practice Forum, Vancouver</td>
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<td>• Pelvi-Perineal Re-Education II: The Physiotherapy Approach for Dyspareunia and Physiotherapy for Male Urinary Incontinence, Vancouver</td>
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<td>• Kinesio Taping Seminar, Victoria</td>
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**Video Recommendation**
MPT student, Heather Leslie, found this nugget and shared it with PABC to be shared with you. Heather says: “I just wanted to pass along a video I found online that does a very elegant job of promoting exercise. Since this is such a fundamental message that we often find ourselves telling patients, it seemed useful and worth sharing.”

It is called **23 1/2 Hours** – http://goo.gl/zVZPM and PABC gives it two thumbs up for delivering a powerful message in a short time in a new riveting delivery style.
Directions in Physiotherapy
Directions is published four times a year: Winter, Spring, Summer and Autumn. Articles on members’ clinical practice are welcome.

The editor retains the right to determine content. Unless specifically indicated, statements do not reflect the views or policies of PABC. Services or goods advertised are not endorsed by PABC.

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Free PABC Knowledge Team Webinars
February 9 - Anatomy of a Literature Search Part 1
February 16 - Anatomy of a Literature Search Part 2
March 14 - Journal Club: Foot Orthoses in the Management of Patellofemoral Pain Syndrome
April 19 - Finding Full-Text Articles
Details at www.bcphysio.org/event_list

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Evening Lecture/Podcast Series
Spring – Keepin’ it Movin’: Expertise in Movement Analysis
Walk this way: Gait Analysis as a Clinical Tool
March 7: with Deb Treloar, BSR, FCAMT
Using gait analysis in the clinic allows us to assess our clients’ movement patterns in a manner that integrates all systems. In this lecture we will look at what information we can gain for assessment purposes as well as how to use our findings as tools to determine the effect of our treatment. Pictures and videos of clinical case studies will be presented to illustrate the basis for clinical reasoning.

New Movement: A Novel Strategy for Hip, Knee and Groin Conditions
April 3: with Dr. Rick Celebritini PhD PT
Join Rick Celebritini as he presents the findings of his recently completed doctoral research investigating the effects of a novel movement strategy. He’ll provide a simple and practical means of modifying high-risk movements for ACL injury such as side-cutting and single-leg landing. The application in the treatment of common clinical conditions such as lumbo-pelvic-hip dysfunction and long standing groin pain will be discussed.

Location/time: Vancouver General Hospital, Vancouver BC, 7:00 – 8:30 pm
Podcasts: distributed to registrants one week following the live lecture
Fees: PABC members: $40 (students $10; new grads $20 - in person only), podcast $30; future members: $60; Podcast “group” rate per site: PABC members $60; future members $120

Fall – What’s “up” in the Upper Extremity?
Join us as local leaders Dr. Tom Goetz, Travis Wolsey and Ron Mattison discuss the management of hand, wrist, elbow and shoulder injuries in athletes.

Weekend Courses
Improving Your Clinical Practice: A workshop on applying evidence and clinical reasoning to your practice.
May 6: with Lenerdene Levesque MSc, FCAMT
Participants will be encouraged to become critical thinkers and reflective practitioners through the practical use of clinical case studies and facilitated group exercises.

Rediscovering Anatomy: Exploring musculoskeletal form and function with cadaver prosections
June 15/16: with Sean Campbell MSc, Majid Alimohammadi Ph.D, & regional experts
This course provides clinicians with a comprehensive 2 day hands on exploration of cadaver prosections under the guidance of instructors from the UBC Department of Anatomy and Regional Clinical Experts

Mobilization of the Nervous System
December 1/: with Sam Steinfeld and Laurie Urban
A comprehensive course on the diagnosis and management of physical dysfunction of the nervous system. With plenty of practical work and the latest neurobiology, clinicians will be able to rapidly merge the material into all existing manual therapy frameworks.

To register for courses or lecture/podcast series, follow these three easy steps:
1. 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

For more information, call PABC at 604-736-5130, ext. 2 or email Andrea Reid at education@bcphysio.org.

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